Health First COLORADO
Colorado's Medicaid Program

Colorado HIBI Program
1550 Larimer St. Box #1000
Denver, CO 80202

Date

Name
Address
City, State, Zip

Dear Health First Colorado Member:

This letter has information about the Health Insurance Buy-In (HIBI) program and how to apply. HIBI is for individuals who have commercial health insurance coverage and are currently enrolled in Health First Colorado (Colorado's Medicaid Program).

Benefits of HIBI

- HIBI can help pay your commercial health insurance premiums.
- HIBI is a program offered **in addition** to your regular Health First Colorado Benefits. You will not lose your Health First Colorado benefits.

Who May Qualify

To qualify for HIBI, you or a member of your family must:

- Be currently enrolled in Health First Colorado.
- Be currently covered, or have access to, a group or individual health insurance plan. These plans are usually through an employer.
- Visit www.mycohibi.com for more information, or call HIBI Customer Service at 1-855-692-6422.

To Apply

Fill out the attached application and return it with all four documents listed below:

1. Premium rate sheet from your employer or insurance representative that lists the cost of the commercial health insurance policies offered to you, and includes the rates for: Individual Only, Individual and Spouse, Individual and Child(ren), and Individual and Family.
2. Summary of benefits (including deductibles, co-pay, and co-insurance rates).
3. A copy of the front and back of your insurance card.
4. Recent paystub that shows your insurance premium has been taken out or other verification of the premium payment (if you are already enrolled).
   - Fax your application and documents to 1-855-226-4424 or mail them to: Colorado HIBI Program, 1550 Larimer St. Box #1000, Denver, CO 80202

Sincerely,

Your HIBI Team

Colorado HIBI Program
1550 Larimer St. Box #1000
Denver, CO 80202

Health Insurance Buy-In (HIBI) Application: Form One

1. Are you or anyone in your family enrolled in Health First Colorado (Colorado's Medicaid Program)? __Yes __No

2. Do you or anyone in your family have commercial health insurance? __Yes__No

   IF YES, which type: __Employer __COBRA __Other

   What is the premium for this policy? $_____

   These premiums are paid/deducted:

   __Weekly __Biweekly __Semi-Monthly __Monthly __Quarterly __Other

   Type of Coverage:

   __Individual __Individual and Child(ren) __Individual and Spouse __Family

   IF NO, do you have access to health insurance through your job? __Yes __No

3. Is your health insurance coverage court-ordered (part of a divorce/separation decree)? __Yes __No

4. Are the doctors and other providers you see in your current health insurance network? __Yes __No

You must have access to employer-sponsored or commercial health insurance to qualify for the HIBI program. If you are not sure whether you qualify, please call 1-855-MyCOHIBI or 1-855-692-6442 to speak with a HIBI program advisor.

Please complete this section with the policyholder's information and signature.

Name of Member:_____SSN:_____DOB:_____

Address:_____

City/ State/ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

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Health Insurance Buy-In (HIBI) Application: Form One (cont'd)

Insurance Company Name:_____

Policy/Subscriber/Member Number:_____

Group Number:_____

Dental Insurance Company Name (if applicable):_____

Effective Date of Policy:_____ End Date:_____

List everyone in your household covered by your policy. Also include anyone who receives Health First Colorado Benefits. (Use extra paper if necessary.)

Name	Social Security Number (Last 4 digits)	Birth Date	Member ID	Relationship to Member	Gender	Medical Condition (e.g., Diabetes, HIV, etc.)

I authorize any person, medical provider, insurance company, or other organization to provide any information about me or my dependent's health insurance, medical treatment and employment to the Department of Health Care Policy and Financing and its Business Associates upon request.

Signature:_____Date:_____

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Health Insurance Buy-In (HIBI) Application: Form One (cont'd)

Please provide the following information to facilitate direct deposit reimbursement of your premium.

Bank Name:_____

Name on Bank Account:_____

Account #:_____

Routing #:_____

Attach a copy of a voided check below:

Please fax or mail a copy of this form to the Colorado HIBI program.

Fax: 1-855-226-4424
Mailing Address: Colorado HIBI Program
1550 Larimer St.
Box #1000
Denver, CO 80202

If you have any questions about this application, call us at: 1-855-692-6442.

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Health Insurance Buy-In (HIBI) Application: Form Two

Complete Form Two only if you purchase health insurance through your employer. You can complete Form Two or provide it to your employer or human resources department for completion.

1. Name of Applicant:_____

2. Employer Name:_____ Employer Federal Tax ID:_____

   Employer Address:_____

   City:_____ State:_____ Zip:_____

   Employer Phone Number:_____ Fax Number:_____

3. Does your company offer employer-sponsored health insurance to employees?
   __Yes __No

   If YES, please attach your company rate sheet showing all rates offered. Also, please provide a Summary of Benefits that includes deductibles, co-pays, and co-insurance amounts for the health insurance plan available to this employee.

4. When is your company's open enrollment for health insurance?

   Start:___/___/___ End:___/___/___

5. Company Contact Information (e.g. human resources representative; benefits coordinator):

   Name(Print):_____ Signature:_____

   Title:_____ Date Signed:_____

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