NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Health Insurance Premium Payment (HIPP) Health Insurance Verification Form
HIPP Program: P.O. Box 95026 Lincoln, NE 68509-5026
Contact: DHHS.MedicaidHIPP@nebraska.gov

The Health Insurance Premium Payment (HIPP) program is a cost savings measure for the State of Nebraska. Any information provided will remain confidential. In order to make a determination, please complete and return this form. The policyholder has authorized the release of information, through the noted signature below, for all required information. If you have questions regarding completion of the form, please contact the HIPP program by the contact information listed above.

Section I: Release of Information (to be completed by the Employee)
By signing, I authorize the release of insurance information (including all covered individuals) to the HIPP program.

1A. Employee Name	1B. Phone Number
1C. Address	
1D. Signature	1E. Date

Sections 2 through 5: Completed by the Employer/Self-Insured

Section 2: Employee Information *Check appropriate box*

2A. Employer/Business Contribution to the Health Insurance Premiums
☐ Yes ☐ No

2B. Employment Status
☐ Full-Time ☐ Part-Time ☐ Laid-Off ☐ Retired ☐ Former

2C. Eligible for Coverage under your Company's Health Plan
☐ Yes ☐ No
If yes, Effective Date:_____ If no, Reason:_____

2D. Currently Enrolled in the Health Plan
☐ Yes ☐ No
If yes, Effective Date:_____

2E. Wellness Credit
☐ Yes ☐ No
If yes, How Much $_____ and Frequency:_____

2F. Any payments that decreases the health insurance premium amount including, but not limited to credits, refunds, contributions, adjustments, etc.
☐ Yes ☐ No
If yes, How Much $_____ and Frequency:_____

2G. Any health insurance related fees that increases the health insurance premium amount including, but not limited to administrative fees, surcharge, penalties, etc.
☐ Yes ☐ No
If yes, How Much $_____ and Frequency:_____

Section 3: Enrolled in Health Insurance Starting with Employee/Policyholder (attach additional page if more than 7)

3A.* Name (Last, First, MI)	3B.* Relationship to Employee/Policyholder	3C.* Currently Enrolled in Health Plan	
	Employee/Policyholder	☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

Section 4: Plan Benefits Covered

4A. Insurance Coverage Type *Check appropriate box for the employee*

☐ Employee only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family ☐ Other:_____

4B. Health Insurance Carrier

Company	
Address	Phone (include area code)
Policy Number	Group Number

4C. Health Insurance Premium Information (exclude dental, vision, life, etc.) Complete the selected coverage level/ tier the employee/policyholder is currently enrolled in. Provide the employer/business and employee/policyholder contributions to the annual premium. Select one:

Coverage Level / Tier	Health Premiums
Employee/Policyholder Only	
Cost to Employer/Business	Annually $
Cost to Employee	Annually $
Employee/Policyholder + Spouse	
Cost to Employer/Business	Annually $
Cost to Employee	Annually $
Employee/Policyholder + Child(ren)	
Cost to Employer/Business	Annually $
Cost to Employee	Annually $
Employee/Policyholder + Family	
Cost to Employer/Business	Annually $
Cost to Employee	Annually $

4D. Frequency of Premium Payment Deductions for Elected Insurance Plan

Weekly	Semi / Bi-Monthly	Monthly
☐ 52 Weeks	☐ 24 Weeks	☐ 6 Months
☐ 50 Weeks	☐ 26 Weeks	☐ 12 Months
☐ 48 Weeks	☐ Other Explain:_____	

Section 5: Employer/Business Representative

5A. HR Representative or Benefits Manager Name	5B. Department
5C. Employer/Company Name	5D. Work Phone (include area code) Ext.
5E. Employer/Company Address	City
5F. State	Zip Code

5G. I certify all information contained here is true and accurate to be best of my knowledge.

Representative's Signature_____ Date_____

This form is not considered complete if not received with the requested attachments.
Please return insurance verification form with insurance rate sheet, Summary of Benefits, and any other supporting documentation explaining insurance credits, refunds, contributions, adjustments or fees to:

Please return all required documentation to:

By mail:
DHHS-HIPP
Medicaid and Long-Term Care
PO Box 95026
Lincoln NE 68509-9966

By email:
DHHS.MedicaidHIPP@nebraska.gov

By Fax: (Attention: HIPP)
402-328-6215

Insurance Verifications Instructions

Section 1: Release of Information (to be completed by the Employee)
1A. Full name of the employee purchasing the health insurance.
1B. Enter the preferred contact phone number.
1C. Enter the full address.
1D. Signature authorizing the release of information for verification.
1E. Signature date.

Sections 2 through 5: Completed by the Employer/Self-Insured
2A. Check appropriate box.
2B. Check appropriate box.
2C. Check appropriate box. If yes, enter effective date of eligibility, e.g. open enrollment, qualifying even. If no, please list the reason, e.g., temporary - not eligible, eligible after waiting period, given a credit to purchase their own insurance.
2D. Check appropriate box. If yes, please list the effective date.
2E. Check appropriate box if yes, amount of the credit and the frequency.
2F. Any credits refunds or adjustments given by the employer or business, if yes, how much and frequency.
2G. Any health insurance related fees that increases the health insurance price, if yes, state how much and frequency.

Section 3: Enrolled in Health Insurance (Starting with Employee/Policyholder)
List the individuals starting with the employee/policyholder covered or eligible for coverage under the health insurance.
3A. Last name, first, and middle.
3B. Enter relationship to employee/policyholder, e.g. child, step-child, spouse, etc.
3C. Check the appropriate box, if currently enrolled in the health plan.

Section 4: Plan Benefits Covered
4A. Insurance Coverage Type, check appropriate box for the type of health insurance coverage.
4B. Health Insurance Carrier, enter the insurance company name, billing address, phone number, policy number, and group number.
4C. Health Insurance Premium Information, complete for the coverage selected. Provide the employer/business and employee/policyholder contributions to the annual premium.
4D. Frequency of Premium Payment, check appropriate box for frequency of deductions the policyholder pays for health insurance annually.

Section 5: Employer/Business Representative Information
5A. List Individual who is completing Sections 2-5 of this form.
5B. List the department represented.
5C. List employer or company name.
5D. List the preferred contact number.
5E. List employer or company address and city.
5F. List employer or company state and zip code.
5G. Representative Signature and date.

This form is not considered complete if not received with the requested attachments.