Clear Form

Minnesota Department of **Human Services**

DHS-1922B-ENG 10-12

Minnesota Health Care Programs

Health Insurance Information Form (HIIF)

Date: _____

To: _____

_____

_____

Case number: _____

Case name: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

We need you to fill out this form. We need information about health insurance coverage. It must include information about you and any of your family members. Information is needed for current coverage and any past coverage. If you do not give us this information, you may not qualify for our health care programs. Your signature on the application form allows us to collect payment from any insurance company while you are enrolled in a Minnesota Health Care Program.

We will share this information with:

- Minnesota Health Care Program Staff
- Medical providers
- Human Services Benefit Recovery Section
- Your spouse or children who live in your household
- The insurance company
- Parents who do not live with a child

If there are any changes in health insurance coverage, provide the information to your worker within 10 days. If you have questions, contact your worker at the above phone number.

1. Do you, your spouse or your children have health insurance, long term care insurance, or prescription drug coverage now? ◯ No – go to question 2 ◯ Yes – fill in below

POLICYHOLDER'S NAME	DATE OF BIRTH	POLICY TYPE ◯ Individual ◯ Employer/Group	POLICY NUMBER

INSURANCE COMPANY NAME	PHONE NUMBER	POLICY BEGIN DATE	POLICY END DATE

CLAIMS ADDRESS	CITY	STATE	ZIP

LIST FAMILY MEMBERS COVERED	What is the total monthly premium amount that you pay? $

DEDUCTIBLES (NOT CO-PAY)	OFFICE CO-PAY	PRESCRIPTION CO-PAY
$ _____ per person in network $ _____ per family in network $ _____ per person out of network $ _____ per family out of network	$	$

EMPLOYER/GROUP NAME ☐ Not employer insurance	EMPLOYER/GROUP NUMBER

EMPLOYER/GROUP ADDRESS	CITY	STATE	ZIP

Case number: _____

COVERAGE TYPES (check each box that applies)

- ☐ 01 Basic Hospital
- ☐ 02 Medical - Surgical
- ☐ 03 Medicare Supplemental Policy
- ☐ 04 Prescription Drugs with Deductible
- ☐ 05 Prescription Drugs with Co-pay of $_____
- ☐ 06 HMO (Health Maintenance Organization)
- ☐ 07 HMO (Medicare)
- ☐ 08 PPO (Preferred provider Organization)
- ☐ 09 TRICARE / CHAMPUS
- ☐ 10 Comprehensive Dental
- ☐ 11 Preventive Dental only
- ☐ 12 Vision Care / Eyeglasses
- ☐ 13 Nursing Home Care
- ☐ 14 Hospital / Surgical only
- ☐ 15 Cancer only
- ☐ 16 Accident only
- ☐ 17 Indemnity Coverage
- ☐ 20 OTC (Over the Counter) Drugs
- ☐ 21 VA (Veteran's Administration)
- ☐ 24 PPO Dental

Employer Insurance Information

EMPLOYEE	EMPLOYER/UNION PAYS $	◯ Monthly ◯ Twice a month ◯ Weekly ◯ Every 2 weeks	AMOUNT YOU PAY $	◯ Monthly ◯ Twice a month ◯ Weekly ◯ Every 2 weeks
SPOUSE/DEPENDENT (do not include employee amount)	EMPLOYER/UNION PAYS $	◯ Monthly ◯ Twice a month ◯ Weekly ◯ Every 2 weeks	AMOUNT YOU PAY $	◯ Monthly ◯ Twice a month ◯ Weekly ◯ Every 2 weeks

2. Answer the questions below regarding past insurance coverage.

1. Did you, your spouse or your children have health insurance coverage in the past four months?	◯ No ◯ Yes
2. Did you, your spouse, or children have health insurance coverage in the past 18 months?	◯ No ◯ Yes
3. Did you or your spouse turn down health insurance offered by your employer?	◯ No ◯ Yes
4. Did you have insurance through your current employer and it ended?	◯ No ◯ Yes – fill in below

DATE INSURANCE ENDED	REASON INSURANCE ENDED

5. Did your employer or your spouse's employer offer health insurance in the past 18 months, but doesn't offer it now?	◯ No ◯ Yes – fill in below

DATE THE EMPLOYER STOPPED OFFERING INSURANCE AS A BENEFIT FOR EMPLOYEES

3. Do you, your spouse or your children have Medicare coverage? ◯ No ◯ Yes – fill in below

PERSON COVERED	MEDICARE ID NUMBER	START DATE OF PART A	START DATE OF PART B
PERSON COVERED	MEDICARE ID NUMBER	START DATE OF PART A	START DATE OF PART B

You may be asked to submit a copy of both sides of your insurance card.

NAME OF PERSON WHO COMPLETED THIS FORM	PHONE NUMBER WHERE WE CAN REACH YOU

SIGNATURE	DATE

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-3274, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.