WYOMING HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (WHIPP)

Summary of the Health Insurance Premium Payment Program:

The Social Security Act (section 1902-1906) allows Wyoming to pay insurance premiums, co-insurance and deductibles for Medicaid recipients to keep their employment and non-employment related health insurance whenever, it is cost effective to do so. Cost effectiveness means the amount paid for premiums and other cost sharing obligations plus the state's administrative cost are less than third party liability payment for the equivalent set of services and amount paid by Medicaid for the same category of service.

Eligibility for the WHIPP program is based on a Medicaid recipient's medical needs and the cost effectiveness to the state of Wyoming. If you or your family member are a Medicaid client, have an active insurance policy and are a high cost utilizer of medical services, the state may pay premiums, deductibles and co-insurance for you.

There are several reasons why having insurance may be helpful for you:

1. Your policy may cover services that may not be covered by Medicaid. If you maintain your private insurance during your Medicaid eligible period, re-enrollment of insurance is not necessary after you are no longer eligible for the Medicaid program.
2. Members of your family who are not eligible for Medicaid will be covered under the private health insurance plan if Medicaid decides that buying a family plan for the Medicaid eligible persons is cost effective.
3. If you, or a family member, qualify for Medicaid due to pregnancy, the State may pay the premiums, deductibles, and co-insurance for you while you are pregnant provided the health insurance covers the pregnancy and it is deemed cost effective. This also applies to Medi-gap policies.

What you must do:

When you apply or re-apply for Medicaid, you must complete the attached WHIPP application form and return it to your caseworker within forty-five (45) days from the date of application for Medicaid if you or a family member are covered under a health insurance policy and meet one or more of the following criteria:

1. Medical bills over the past six (6) months exceeding the amount of monthly premiums. Attach bills you have paid or insurance explanation of benefits.
2. Temporary disability as determined by a medical professional; where you expect continuous care for a period of more than six (6) months. Please attach a copy of the plan of treatment from your health care provider.
3. Include a copy of the policy that outlines the services that are covered, what cap/lifetime limits that exist on the policy. This also includes any co-pays and/or deductibles for services. (Inpatient/Outpatient hospital surgery, e.g.) (If applicable)

If you feel that you meet the criteria outlined above please mark yes and continue filling out this application. If **no**, please sign and date the cover letter and return it back to your DFS caseworker. Do not complete the remaining portion of the application.

Yes ____ (Continue onto application) **No** ____ (**Stop here** and sign and return to DFS)

Signature: _____ Date: _____

State Responsibility:

All WHIPP applications will be forwarded to ACS for processing within seven (7) working days.

ACS will verify the information, and make the cost effectiveness determination. You and your caseworker will be notified within forty-five (45) days from the day of the WHIPP application being received by the Medicaid agency whether you are in the Health Insurance Premium Payment program.

HEALTH INSURANCE VERIFICATION FORM

OM-WHIPP 1a

I hereby authorize my employer/former employer or insurance carrier named below to furnish the Wyoming Department of Health, Office of Medicaid any confidential information requested regarding my insurance coverage. I hereby forever release and discharge my insurance carrier from any liability for divulging such information; notwithstanding the fact this authorization expires on termination of Medicaid eligibility.

Applicant Name	Client Number	SSN	Signature	Date

Address	City	State	Zip	Phone Number

HEALTH INSURANCE INFORMATION

Name/Address of Carrier

Is the policy employment related? Yes No
Is the policy individually (personally) purchased? Yes No

If yes, name of employer and address

Policy Holder

Policy Number

Group Number

Group Name

What is the charge to cover the subscriber/employee for premiums?

$_____ single plan $_____ family plan

weekly biweekly monthly semimonthly other _____

If the policy is employment related the date that the payroll deduction will begin _____

Deductible:_____ per: _____ Coinsurance/Co-pay:_____
Other: _____
Pregnancy Deducible (if applicable): _____

Can the employer and/or insurance company accept payment from the Office of Medicaid for premiums in lieu of a payroll deduction or private payment from the policy holder?

Yes No

If YES, enter employer/insurance federal tax ID# and address where premium payments should be mailed:

Tax ID: _____
Address: _____
_____
_____

If, employment related, is there a waiting period before they can enroll in the health plan?

Yes No

If yes, date employee is eligible to enroll and the reason why there would be a delay in coverage?

Coverage (mark all that apply)

Hospital	Physician	Surgical	Major Medical	Accident
Indemnity	Dental	Vision	Pharmacy	Supplement
Auto	Disease	Nursing Home	Pregnancy	HMO

Persons covered by policy:

Name	SSN	D.O.B.	Client Id

Comments:

Authorized Signature	Phone Number	Date

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Wyoming Office of HealthCare Financing / EqualityCare
Health Insurance Premium Payment
Medical History Questionnaire

1. How many prescriptions are filled each month for the Medicaid recipients in your household who are covered under this insurance policy? _____ Average monthly cost $ _____
2. Are any of the Medicaid recipients covered under this policy periodically institutionalized or currently living in an institution (mental institution, nursing home, or hospital, etc)? Yes ____ No ____
3. Check all following conditions that apply to any Medicaid recipients covered under this policy. List the name of the person with each condition and how often medical care is needed to treat the condition.

Condition	Yes	If yes, name of person with condition	How often is medical care required?
Diabetes			
Blood Disorder			
Cancer (please specify type)			
Mental Illness/Retardation			
Pregnancy			Due Date?
Heart Condition			
Asthma/Respiratory Ailment			
Scoliosis/Back Injury			
Stroke/Head Injury			
Organ transplant (explain)			
Seizure Disorder			
HIV Positive / Acquired Immune Deficiency (AIDS)			
Alcoholism / Drug Addiction			
List other Disease Condition			

4. Are there any of the conditions checked "Yes" above excluded from coverage under this health insurance plan as a pre-existing medical condition? Yes _____ No _____

If yes, list conditions not covered and when will they begin to be covered (if applicable)

_____

_____