MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-44

Distribution: Local Health Departments

Issued: September 1, 2007

Subject: CSHCS Application for Insurance Premium Payment

Effective: October 1, 2007

Programs Affected: Children's Special Health Care Services

When a Children's Special Health Care Services (CSHCS) client loses or obtains access to private health insurance coverage, Medicare Part B, or Medicare Part D, CSHCS may assist in paying toward the cost of the premium. It must be deemed cost effective for CSHCS and the client/family must have a financial hardship that interferes with their ability to pay for the coverage.

Effective October 1, 2007, the following documentation is required to apply for CSHCS payment of insurance premiums:

- A completed CSHCS Application for Payment of Insurance Premiums form (MSA-0725).
- Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
- Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
- Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
- Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

The client/family should contact the Local Health Department to obtain the MSA-0725 and for assistance in completing the form.

The CSHCS Application for Payment of Health Insurance Premiums (MSA-0725) is a new form. A copy of the form is attached to this bulletin.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health
Children's Special Health Care Services (CSHCS)

Application for Payment of Health Insurance Premiums

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)	2. CSHCS ID Number	3. Client's Date of Birth (MM/DD/YYYY) / /
4. Does Client have Medicare Part B? ☐ **YES** ☐ **NO**	5. Does Client have Medicare Part D? ☐ **YES** ☐ **NO**	

SECTION TWO – Insurance Information

Is this case for:
☐ **COBRA** - Answer questions 6-22
☐ **Insurance Premium (new or continuing coverage)** - Answer questions 11-22

6. Reason COBRA was offered **OR** may be available	
7. Date of qualifying event / /	8. Date of COBRA notice to employee / /
9. Date COBRA election form was signed (if applicable) / /	10. Has first COBRA payment been made? ☐ **YES** ☐ **NO** If yes, list date / /
11. Is insurance coverage through employer? ☐ **YES** ☐ **NO**	12. Name of employee (if applicable)
13. Name of employer (if applicable)	14. Name of insurance contact person
15. Phone number of insurance contact person ( )	16. Name of insurance company
17. Insurance contract number/group number	18. Premium cost per month for client's coverage $.
19. Date next premium is due / /	20. Date of contract renewal *(when rate could change)* / /
21. Name and address of company where premium payments are to be sent:	
22. Reason family is unable to pay premium:	

SECTION THREE – Health and Medical Information

23. What is the client's CSHCS covered diagnosis?			
24. What does the health insurance cover:	☐ **HOSPITAL** ☐ **VISION**	☐ **DOCTOR VISITS** ☐ **DENTAL**	☐ **PRESCRIPTIONS**
25. What are the expected future medical needs for the CSHCS client?			

26. Is it likely the client's insurance will cover these medical needs? Explain.

27. What special health care needs are **not** covered by the client's health insurance?

28. Are there other health insurance coverages for which the client might be eligible (e.g. Medicare Part B, Medicare Part D, other private health insurance, etc)? ☐ **YES** ☐ **NO**

Explain:

29. Additional Comments:

Attach the following information:

- Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
- Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
- Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
- Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

Mail this application and attachments to:
MDCH/CSHCS
Insurance Specialist
320 S. Walnut St., 6th Floor
Lansing, MI 48913

OR

Fax: 517-335-8055

For questions call:
Family Phone Line: 1-800-359-3722 and ask for the Insurance Specialist

SECTION FOUR – Verification and Signature

- **By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.**
- **I understand that I may need to show proof of this information.**
- **I understand that the information shared might relate to HIV, ARC, or AIDS if the Client has those conditions.**

Signature of Legally Responsible Party or Adult Client **Date Signed**

MDCH USE ONLY

MDCH Action	
☐ **APPROVED** ☐ **DENIED**	**MDCH Signature** **Date**

Copy Distribution:
Client/Family
LHD

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is voluntary, but is required if CSHCS program services are desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.