Michigan Department of Health and Human Services
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 Contact Phone Number<br>- - | 4. Client's Date of Birth (MM/DD/YYYY)<br>/ / | |
| 5. Does Client have Medicare Part B?<br>☐ **YES** ☐ **NO** | 6. Does Client have Medicare Part D?<br>☐ **YES** ☐ **NO** | 7. Does Client have MIChild?<br>☐ **YES** ☐ **NO** |

## SECTION TWO – Insurance Information

Is this case for:

☐ **COBRA** - Answer questions 8-24

☐ **Insurance Premium (new or continuing coverage)** - Answer questions 13-24

| 8. Reason COBRA was offered **OR** may be available: | |
|---|---|
| 9. Date of qualifying event<br>/ / | 10. Date of COBRA notice to employee<br>/ / |
| 11. Date COBRA election form was signed (if applicable)<br>/ / | 12. Has first COBRA payment been made? ☐ **YES** ☐ **NO**<br>If yes, list date / / |
| 13. Is insurance coverage through employer? ☐ **YES** ☐ **NO** | 14. Name of employee (if applicable) |
| 15. Name of employer (if applicable) | 16. Name of insurance contact person |
| 17. Phone number of insurance contact person<br>( ) | 18. Name of insurance company |
| 19. Insurance contract number/group number | 20. Premium cost per month for client's coverage<br>$ . |
| 21. Date next premium is due<br>/ / | 22. Date of contract renewal *(when rate could change)*<br>/ / |
| 23. Name and address of company where premium payments are to be sent: | |
| 24. Reason family is unable to pay premium: | |
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| | |
| | |

## SECTION THREE – Health and Medical Information

| 25. What is the client's CSHCS covered diagnosis? | | | |
|---|---|---|---|
| 26. What does the health insurance cover: | ☐ **HOSPITAL** | ☐ **DOCTOR VISITS** | ☐ **PRESCRIPTIONS** |
| | ☐ **VISION** | ☐ **DENTAL** | |
| 27. What are the expected future medical needs for the CSHCS client? | | | |
| | | | |

| 28. Is it likely the client's insurance will cover these medical needs? Explain. |
|---|
| |
| 29. What special health care needs are **not** covered by the client's health insurance? |
| |

| 30. 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: |

| 31. 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:**
MDHHS/CSHCS
Insurance Specialist
PO Box 30734
Lansing, MI 48909

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**

_____

**MDHHS USE ONLY**

| **MDHHS Action** ☐ **APPROVED** ☐ **DENIED** | |
|---|---|
| | **MDHHS Signature** **Date** |

**Copy Distribution:**
Client/Family
LHD

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

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