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

Application for Payment of Health Insurance Premiums

Please complete as many fields as possible in the application. In addition, a complete application will include:

- ☐ 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: 517-335-9491

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

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)	2. CSHCS ID Number
3. Client's Contact Phone Number - -	4. Client's Date of Birth (MM/DD/YYYY) / /
5. Client's Email Address	6. Client's Preferred Contact Method ☐ **EMAIL** ☐ **PHONE**

SECTION TWO – Insurance Information

Is this case for:

- ☐ **Employer-Based Insurance**
- ☐ **Marketplace Insurance Policy**
- ☐ **Medicare Part B**
- ☐ **Medicare Part D (Prescription Drug Coverage)**
- ☐ **COBRA**
- ☐ **Other:**

7. Is insurance coverage through employer? ☐ **YES** ☐ **NO**	8. Name of employee (if applicable)
9. Name of employer (if applicable)	10. Name of insurance contact person
11. Phone number of insurance contact person ( )	12. Name of insurance company
13. Insurance contract number/group number	14. Premium cost per month $.
15. How many people are covered by this policy (including policy holder)?	16. Date next premium is due / /
17. Date of contract renewal *(when rate could change)* / /	
18. Name and address of company where premium payments are to be sent:	
19. Describe any financial circumstances that should be considered when evaluating this application?	

SECTION THREE – COBRA Information (If applicable)

20. Reason COBRA was offered OR may be available:	
21. Date of qualifying event: / /	22. Date of COBRA notice to employee: / /
23. Date COBRA election form was signed (if applicable) / /	24. Has first COBRA payment been made? ☐ **YES** ☐ **NO** If yes, list date: / /

SECTION FOUR – 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. 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:

SECTION FIVE – 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.**
- ☐ **I will be notified in writing if my application for the CSHCS Insurance Premium Benefit Payment Program has been approved.**
- ☐ **If approved, CSHCS will pay the portion of my insurance premium that is associated with the CSHCS-enrolled individual.**
- ☐ **Any refunds or reimbursements received from my insurance provider must be submitted to the CSHCS Insurance Premium Benefit Payment Program.**

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

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MDHHS USE ONLY

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

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

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.
Call 800-359-3722 (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-359-3722 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-359-3722 (رقم هاتف الصم والبكم: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-359-3722 （TTY 711）
Syriac (Assyrian)	ܙܘܗܪ̈ܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬܠܘܢ ܕܡܫܬܡܫܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ (TTY 711) 800-359-3722
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-359-3722 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-359-3722 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-359-3722 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 800-359-3722 (TTY ১ 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-359-3722 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-359-3722 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-359-3722 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-359-3722（TTY 711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-359-3722 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-359-3722 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-359-3722 (TTY 711).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.