NORTH CAROLINA HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
Application Form

Name of Applicant / Recipient	North Carolina Medicaid I.D. Number (Required)
Applicant/Recipient Address	Social Security Number
City, State, Zip	Area Code/Phone Number
Name and Address of Insurance Carrier	Policyholder's Name
	Policy Number
	Policyholder's Social Security Number
	Premium Amount /Month

Source of Insurance (check one) ☐ Employee Group Plan ☐ Self Employed

☐ COBRA

How are premiums paid? (Check appropriate box)

1. ☐ Paid by insured to insurance carrier
2. ☐ Paid by insured to employer
3. ☐ Payroll deduction

Type of policy (Check appropriate box)

1. ☐ Single Coverage
2. ☐ Family Coverage

Name of Employer: _____

Address of Employer: _____

_____

Employer Telephone Number: _____

This person has been diagnosed as having _____ .

This person has been tested positive for (HIV). ☐ Yes ☐ No

If yes, please attach a copy of the most recent laboratory test.

This form must be accompanied by an itemization from the private insurance carrier for all claims submitted for the previous three months.

Submit completed form to:

HIPP Coordinator
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508
(919) 647-8100 or 1-800-662-7030