HEALTH INSURANCE PREMIUM PAYMENT HIPP for Kids (HFK) PROGRAM
Cost Sharing of Co-pays, Deductibles and Co-insurance

HFK provides cost sharing to the Medicaid eligible member under age 19 and their parent when they are enrolled in a qualified employer-sponsored health plan and participating in HFK. Cost sharing payments are limited to items/services covered by both the qualified employer sponsored health plan and the State Plan for Medicaid.

Reimbursement of Cost Sharing
The policy holder must submit the Cost Sharing Medical Expense Form to request reimbursement. Medical claims information is evaluated on a quarterly basis. Please refer to the table below:

Medical Expense Period	*Verification Deadline	Reimbursement Month
January thru March	May 5th	June
April thru June	August 5th	September
July thru September	November 5th	December
October thru December	February 5th	March

*If the 5th is a weekend day or a holiday the next business day is the due date.

In addition to submitting the Cost Sharing Medical Expense form below, the policyholder must submit:

- copies of itemized medical bills received from the medical provider **showing the CPT codes** (the prescription drug name is required for pharmacy services and must include the person who received the prescription);
- a copy of the Explanation of Benefits (EOB); and
- a copy of the canceled check, bank statement or receipt showing payment of the medical bill for each expense.

All prescriptions must be detailed on the Cost Sharing Medical Expense Record, one drug per line with the name of the drug in the "type of service field" or they will not be considered for reimbursement for that quarter.

Cost sharing is processed by the 17th of the Verification Deadline month. Checks are mailed the last Friday of the following month. Expense documentation received after the 5th deadline will not be processed.

Please note HFK only provides cost sharing for services covered by the health plan approved under the HFK program. **If the policy holder has a separate dental/vision plan for which HFK is not providing premium assistance, no cost sharing is permitted**. However, for the Medicaid eligible child, the servicing provider can bill Medicaid for potential cost sharing. Additionally, no payment is available for co-insurance/deductibles for services rendered by out of network providers for the employer sponsored group health plan.

The policy holder will be informed in writing of any requests for reimbursement that are denied. If all requested reimbursement is issued, no written notice will be sent.

Medicaid Eligible Members
Medicaid program providers must bill all other third-party insurance providers for items/services rendered for the Medicaid eligible member prior to billing Medicaid, as Medicaid is the payer of last resort. If the provider does not participate in the Medicaid program, the service may be eligible for cost sharing for the Medicaid eligible under age 19 when the service is also a Medicaid covered service.

Non-Medicaid Family Members (limited to parents only)
For expenses that meet program criteria, cost sharing for parents enrolled in the employer sponsored health plan is limited to the services covered by that plan and covered by the Medicaid State Plan.

Effective Date for Cost Sharing for Parents
Cost sharing for items and services rendered begins on or after the effective date of enrollment in the HIPP for Kids Program. Cost sharing will continue while there is active participation in the HIPP for Kids Program.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
COST SHARING MEDICAL EXPENSE RECORD – HFK PROGRAM

Name: _____ **Phone Contact Number: _____**

HIPP For Kids Case Number: _____ **HIPP for Kids Case _____**

Expense Period: _____

I understand, agree and certify that the information provided below is accurate and correct and that submission of documentation that has been altered or false information is cause for referral to the DMAS Recipient Audit Unit for review for fraud. Additionally, I understand that all decision on reimbursement are made in accordance with the policy and procedures governing the HFK Program.

COST SHARING MEDICAL EXPENSE RECORD:

NAME MEDICAID CHILD UNDER 19/PARENT WHO RECEIVED SERVICE	RELATIONSHIP TO EMPLOYEE	NAME OF SERVICES* PROVIDER	TYPE OF SERVICE RECEIVED	SERVICE DATE**		AMOUNT YOU PAID
				FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)	

					TOTAL THIS PAGE	$
					GRAND TOTAL FOR MULTIPLE PAGES	$

Participant's Signature:_____ **Date:_____**
(Required to process reimbursement)

***** Provider of Services means hospital, doctor, dentist, drugstore, medical supply store, etc.
****** Service date refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it

Please be advised that the preferred method for submission of documentation to the HIPP unit is by:

- Emailing scanned documents to the HIPPcustomerservice@dmas.virginia.gov, address; or
- Faxing documents to the HIPP fax # @ 804-452-5447.