Need help? Call: **1-800-424-3310** or Email: CTDPHMRXEnroll@primetherapeutics.com

Fax Application to: **1-800-424-7642**

Eligibility Criteria:

To be eligible for CIPA, individuals must:

- Be actively enrolled in CADAP;
- Be actively enrolled in a CIPA approved health insurance plan which meets the minimal essential requirements of the Affordable Care Act (ACA);
- **Fill prescriptions using CADAP network pharmacies (can be found on the CT DPH website:** https://CTDPH.magellanrx.com**) and utilize CADAP as the secondary payer.**

CIPA Covered Insurance Plans:

- Access Health CT Exchange Plans: Platinum, Gold and Silver plans are covered
- Employer-sponsored plans
- Covered Medicare Advantage and Medicare D plans are located on the CT ADAP website here: https://CTDPH.magellanrx.com

IF YOU HAVE A MEDICARE PLAN, ONLY MEDICARE PART D AND MEDICARE ADVANTAGE PLANS QUALIFY. MEDICARE SUPPLEMENTAL PLANS ARE NOT ELIGIBLE FOR PREMIUM ASSISTANCE.

Supporting Documentation Needed:

- Copy of the front and back of your insurance ID card
- Copy of most recent monthly insurance premium statement
- For employer paid insurance:
  - Provide an address on where to send payments
  - Provide a copy of current paystub (within the last month)
  - Ensure employer accepts third-party payments

If your insurance coverage is changing:

- Submit a copy of your updated insurance ID card
- Submit a copy of your updated monthly premium statement

(Form continued on next page.)

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APPLICANT'S INFORMATION

First Name: ☐☐☐☐☐☐☐☐☐☐☐ **MI:** ☐ **Last Name:** ☐☐☐☐☐☐☐☐☐☐☐

Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Box or Apartment Number (if applicable): ☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Date (MM-DD-YYYY): ☐☐ – ☐☐ – ☐☐☐☐

APPLICANT'S INSURANCE INFORMATION

1. Do you or anyone in your family have health insurance or have applied for health insurance?

   ☐ Yes ☐ No

   1a. If YES, which type?

   ☐ Health Exchange ☐ Employer ☐ COBRA ☐ Other

   1b. If OTHER, provide details:

   ____

2. Type of health coverage:

   ☐ Medicare ☐ Non-Medicare

3. What is the premium for the policy (if known)? $________________________

4. These premiums are paid/deducted:

   ☐ Weekly
   ☐ Every other week
   ☐ Twice Monthly
   ☐ Monthly
   ☐ Quarterly
   ☐ Other

(Form continued on next page.)

POLICY HOLDER'S INFORMATION

Please completely fill out the policy holder information below.

Policy Holder's First Name: **MI:** **Policy Holder's Last Name:**

Social Security Number: – – **Date of Birth (MM-DD-YYYY):** – –

Street Address:

Box or Apartment Number (if applicable):

City: **State:** **Zip Code:**

Home Phone: – – **Cell Phone:** – –

Email Address:

☐ Yes, it is okay to send important information about CIPA to my email address or home address provided above. (If yes, select a method below.)

☐ Send to my email address ☐ Send to my home address

Insurance Company: ____

Policy Number (Mandatory): ____________________________________

Group Number: ____________________________________

Effective Date of Policy: ____________________________________

End Date: ____________________________________

(Form continued on next page.)

POLICY HOLDER'S INFORMATION (*CONTINUED*)

If Employer Sponsored Insurance, please provide name of HR representative:

Employer Contact Name:

Street Address:

City: **State:** **Zip Code:**

Phone Number:

– –

☐ I authorize Pool Administrators Inc. to contact my employer or employer representative listed above to coordinate premium payment set up, if necessary. (**This information is not required to process your premium assistance application but may be used to help expedite and coordinate timely and correct payments. DPH and its and affiliates will make every effort to protect your health information.**)

List all persons covered by the policy:

Name	Social Security Number	Date of Birth	Gender

(Form continued on next page.)

ADDITIONAL CONTACT INFORMATION (OPTIONAL)

Please provide the name of your authorized representative (i.e., power of attorney, case manager, etc.) that has your permission to coordinate insurance services.

Representative's First Name: **MI:** **Representative's Last Name:**

Phone Number: – – **Date (MM-DD-YYYY):** – –

Title of Authorized Representative:

Name of Agency:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND COORDINATE BENEFITS

I hereby authorize the Connecticut Department of Public Health to share my information with its contractors for the purpose of coordinating my insurance benefits. I acknowledge that as a condition of this premium assistance, I must fill my medications using an in-network pharmacy and that the Department must be billed as secondary payer. I acknowledge that failure to adhere to the aforementioned stipulations may result in the Department's cancellation of my premium assistance and may request reimbursement of the expenses incurred.

I understand that the Department of Public Health will make every effort to protect my health information. The Department's contractors will work closely with the individual(s) listed above, if named, to coordinate my insurance benefits. In the event that the Department or its contractors disclose my information without my permission, I will be notified in writing. I agree to indemnify and hold harmless the Department and its contractors in the event my health information is disclosed through no fault of the Department.

Signature **Date**

REMINDER: Please include the supporting documentation needed for your health insurance as outlined on cover page (page 1) of this application.

Please contact Magellan at 1-800-424-3310 if you have questions about our application.