RETURN TO: ________________
Meeker County Social Services
114 N Holcombe Ave, Suite 180
Litchfield, MN 55355

STAFF USE ONLY
Mets: ____________________
MX: _____________________
X: ______________________

REQUEST FOR HEALTH INSURANCE PREMIUM REIMBURSEMENT

You must provide proof of the cost of the premium. (Statement from the Insurance Company, pay stub with health insurance deductions, etc.)

Month Requested ______________________

Insurance Company ____

Client Name and DOB	PMI/Program Office Use Only	Obligation Number Office Use Only	Medical/Dental/Vision	Premium Amount

Payment made to: ________________________________ Social Security Number: _____________________________________
Address: ________________________________
________________________________ ( ) Check if new address

I declare under penalty of law that this claim is just and correct, that the money charged was for the purpose stated and that the coverage was actually provided. I have read and agree to guidelines stated on the reverse side of the claim as they apply to me.

Signature ____ **Date** __________________________________

To Be Certified by Financial Worker

Signature: ______________________________

Date: ______________________________

You must provide verification of the premium amount that you have paid or been charged each month. This verification needs to show the date and amount paid or deducted from your pay.

Reimbursement can only be made for people who are on a Minnesota Health Care Program (excluding persons on Minnesota Care) at the time the health insurance is in effect.

You must report changes in your health insurance to your worker within 10 days of the change. These changes include, but are not limited to: an increase or decrease in the premium amount; an increase or a decrease in the policy deductible; co-pays or coverage; a change in the number of people covered under the insurance policy; ending coverage under a specific insurance carrier; starting coverage under a specific insurance carrier.

Claims are paid during the third week of each month. You need to return your signed request with verifications to our agency by the 3rd of each month. Claims must be submitted within 90 days of billing or payment date to be eligible for reimbursement.

Appeals

You have the right to ask for a hearing if your request for reimbursement is denied. You can ask for a hearing by writing to your worker or by writing to:

Minnesota Department of Human Services
Appeals and Regulations
P.O. Box 64941
St. Paul, MN 55164-0941