

PREMIUM REFERRAL FOR PRIVATE HEALTH INSURANCE (PHI)D

Today's Date: _____

**Return Referral Via mail or Shuttle
to: PHI Premium Coordinator
DMAP Claims Management, HFO
Human Services Building
500 Summer St NE E44
Salem OR 97301-1079**

Client Information:

Program: _____ Branch: _____ Case Number: _____
Case Name: _____ Recipient Name: _____
Worker's Name and Phone Number: _____

Insurance Information:

Policy holder's name: _____ When are premiums due? monthly quarterly
Policy/Group # _____ Premium Amount \$ _____
Date next premium due? _____
Name and address of health insurance company: _____ Name, address, phone number of sponsoring employer: _____

Medical Condition/Diagnosis (this area must be completed):

Please specify any major medical conditions or other medical information that justifies premium payments.

**ATTACH the
following:**

A copy of the private health insurance ID card.

An original signed/dated "Authorization for Use and Disclosure of Health Information" (DHS 2099), allowing DHS to obtain applicant's information from the employer/health insurance carrier.

A copy of the COBRA approval letter, if premium request is for COBRA coverage.