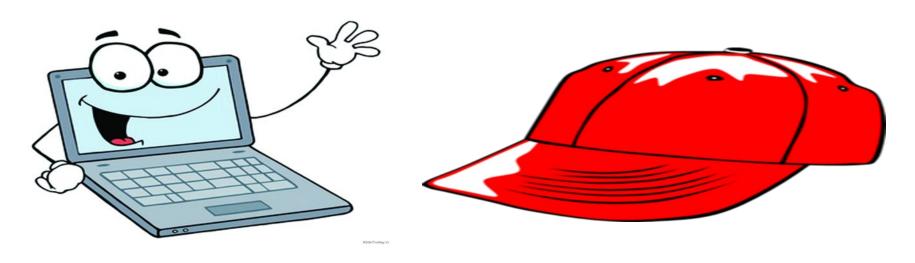
Red Cap: HIPP Electronic Application Tutorial

September 1, 2018



Welcome to HIPP Online!

Department of Medical Assistance Services

Getting Started on your HIPP Journey

- Before you begin your HIPP Application there are documents that you should already have prepared so that you are able to complete the application in one sitting. The documents that are required to process your HIPP Application are listed below:
 - 1. Insurance Plan Summary or Summary of Benefits (Required)
 - Copy of your most recent paystub (that reflects your insurance premium deduction) (Required)
 - An Employer Insurance Verification form, sign and dated by your employer (Required)
 - A front and back image of each unique insurance card is required;
 Medicaid recipients only . (Required)
 - Other supporting documents to upload (Examples: Power Of Attorney, Custody Order, Executor) (Not Required)



Examples of a Plan Summary or Summary of Benefits

Plan Summary

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

blue of california

Full PPO Combined Deductible 10-250 90/70

Coverage Period: Beginning On or After 1/1/2018

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com or call 1-888-256-1915. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other

	derlined terms see the Glossary. You can view the Glossary at healthcare.gow/sbc-glossary or call 1-866-444-3272 to request a copy.				
Important Questions	Answers	Why This Matters:			
What is the overall deductible?	\$250 per individual / \$500 per family for participating providers; \$250 per individual / \$500 per family for non- participating providers.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .			
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>healthcare goufcoverage/preventive-care-benefits</u> .			
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.			
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$1,250 per individual / \$2,500 per family for participating providers; \$3,250 per individual / \$6,500 per family for non-participating providers.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.			
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .			
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>blueshieldca.com/lap</u> or call 1-888-256-1915 for a list of <u>network</u> <u>providers</u> .	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the <u>difference between the <u>provider</u>'s charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>perhownk provider</u> might use an <u>out-of-network provide</u> for some services (such as lab work). Check with your <u>provider</u> before you get services (such as lab work). Check with your <u>provider</u> before you get services on use in the plan's the plan's a billion to be a provider to the plan's the plan's the plan's the plan's the plan's a billion to the plan's the plan's the plan's the plan's the plan's a billion to the plan's the plan's a billion to be plan's the plan's a billion the billion the billion the plan's a billion the billion the</u>			
Do you need a <u>referral</u> to	No.	You can see the specialist you choose without a referral.			

Summary of Benefits

BlueChoice Advantage

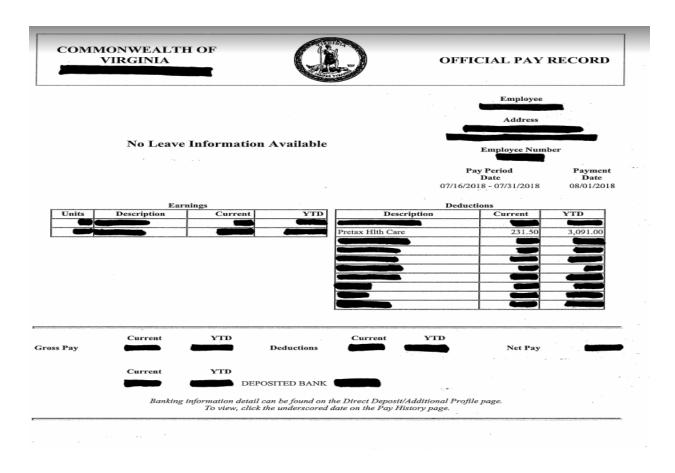
Summary of Benefits

Services	In-Network You Pay ^{1,2}	Out-of-Network You Pay ^{1,3}	
	Visit www.carefirst.com/doctor to locate pr	oviders	
FIRSTHELP—24/7 NURSEADVICE LINE			
Free advice from a registered nurse. Visit www.carefirst.com/needcare to learn more about your options for care.	When your doctor is not available, call Firsti- registered nurse about your health question		
BLUE REWARDS			
Visit www.carefirst.com/bluerewards for more information	Blue Rewards is an incentive program where you can earn up to \$600 for taking an active role in getting healthy and staying healthy.		
ANNUAL DEDUCTIBLE (Benefit period) ⁴			
Individual	\$1,000 (combined in- and out-of-network)	\$1,000 (combined in- and out-of-network)	
Family	\$2,000 (combined in- and out-of-network)	\$2,000 (combined in- and out-of-network)	
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit perio	d) ^c		
Medical ⁴	\$3,000 Individual/\$6,000 Family	\$6,000 Individual/\$12,000 Family	
Prescription Drug ⁴	\$2,000 Individual/\$4,000 Family	All drug costs are subject to in-network out of-pocket maximum	
LIFETIME MAXIMUM BENEFIT			
Lifetime Maximum	None	None	
PREVENTIVE SERVICES			
Well-Child Care (including exams & immunizations)	No charge*	CareFirst pays 100% of Allowed Benefit	
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 40% of Allowed Benefit	
Breast Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit	
Pap Test	No charge*	CareFirst pays 100% of Allowed Benefit	
Prostate Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit	
Colorectal Cancer Screening	No charge*	CareFirst pays 100% of Allowed Benefit	
OFFICE VISITS, LABS AND TESTING			
Office Visits for Illness	\$20 per visit	Deductible, then 40% of Allowed Benefit	
Imaging (MRA/MRS, MRI, PET & CAT scans) ²	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
Lab ²	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
X-ray ⁷	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
Allergy Testing	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
Allergy Shots	\$5 per visit	Deductible, then 40% of Allowed Benefit	
Physical, Speech and Occupational Therapy ^a (limited to 30 visits/injury/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
Chiropractic (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)	
EMERGENCY SERVICES			
Urgent Care Center	\$20 per visit	Deductible, then 40% of Allowed Benefit	
Emergency Room—Facility Services	Deductible, then 20% of Allowed Benefit, \$50 per visit	In-network deductible, then 20% of Allower Benefit, \$50 per visit	
Emergency Room—Physician Services	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allower Benefit	
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	



Examples of a Paystub with health insurance premium deduction

The health insurance premium deduction is visible on the right side of this example



Employer Insurance Verification (EIV) Form Example

1st and 2nd Page of the EIV document

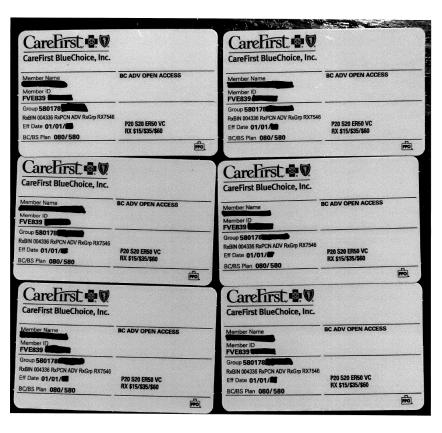
	Health Insurance 600 E. Bro. (804) 225-423 Fa: mail Address: Hill	of MEDICAL ASS ce Premium Payn ad Street, Richm 6 / (800) 432-5924 x Number: 804-45 PPCustomerServ	ISTANCE SERV nent Programs ond, VA 23219 I (in Virginia onl 2-5447 ice@dmas.virgi	ICES Unit (y)	
My signature serves as a Employee Name: John Address: 183 Main	Doe	Ph	one Number:		
INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY If self-employed the policyholder must complete as the employer. SECTION 1 – EMPLOYEE INFORMATION					
Employee Name (Last, First, MI): Ooc , John	Full SSN:	3 - 1234	(MM/DD/YY) Date of Birth: 0	1 /01 / 1980	
1a. Employee Status □ Full-T Date Hired: □ / 2 / 18 1c. School Employee? □ Yes □ 1d. If 1c answer is yes, check appl	1b. Retiree? ☐		No.	urrently enrolled in the Health Plan? No Effective Date: 1/24 //8	
	IIP (Starting with	h Employee) - A	ttach an additi	onal page if more than 7	
Name (Last, First MI)	Full SSN	Date of Birth	Relationship	Currently Enrolled in Plan	
Doe John A.	111 - 11 - 0123	01 /01 / 1985	Employee		
Doc . Jane B.	111 - 23 - 3410	01 /01 / 1981	Spouse	⊠ Yes □ No	
Doc Will C.		01 /01 / 3000	CF:77	¥ Yes □ No	
Doe Kim O.		01 /01/2010		⊠ Yes □ No	
Not / Mar No		/ /	CMIG	☐ Yes ☐ No	
	T	1 1		☐ Yes ☐ No	
	+	1 1		□ Yes □ No	
SECTION 3 - COVERAGE			ODEN	NROLLMENT INFORMATION	
3a. If the employee is currently en of the following:	iloyee + Child	of coverage? Select one Family Other	3b. Effective Da	ate (MM/DD/YY): <u>07 / 24 / 16</u>	

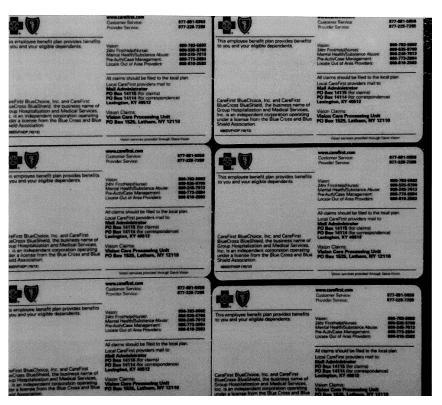
Frankrise Name(t F		rease indicat	te the Cost ar	nd benefits for the o	overage you nave	selecteu.)	
Employee Name(Last, F	11St, MI): Ose ,	John, A.		193 - 33 - 15	34		
Name and Address of Medical Insurance Company:					of Dental Insurano	e Company:	
Blue Shield of C	alifornia						
50 Geals 5+.		San Farne	SEO,CA 94	105-1808			
Insurance Company Pho	one: (415) 2	4 - 5000		Insurance Compan			
Insurance Policy/Group Number: W0065286			Insurance Policy/Group Number:				
Does policy have a health savings account (HSA)? ☐ Yes No			Name and Address of Vision Insurance Company:				
What are the annual de Individual \$ 2.50		health insurar ly \$ 500	nce:	Incurance Compan	Insurance Company Phone; ()		
Tunianna à 4'20	Fallill	3 5 200		Insurance Policy/G			
Type of Health Plan				Services Covered	Under the Health	Plan	
(Check all that apply):	- M - P I			(Check all that app	oly):		
Comprehensive Majo	ir medical			Medical			
M HMO/PPO				Pharmacy			
Hospital Only					Vision		
Other				Dental			
Provide Employer & Em				ance Premium Info	rmation.		
Coverage	Medical	Dental	Vision				
Type Employee Only	Premium	Premium	Premium		f Premium Paymei		
Cost to Employer	1.				mployee's elected pl		
Cost to Employer Cost to Employee	\$	\$	\$	Medical Premium	Dental Premium	Vision Premium	
Cost to Employee	\$	\$	\$				
Employee + Spouse				Weekly:	Weekly:	Weekly:	
Cost to Employer	\$	\$	\$	☐ 50 Weeks	50 Weeks	50 Weeks	
Cost to Employee	\$	\$	\$	48 Weeks	48 Weeks	48 Weeks	
Employee + Child							
	s ·	\$	ŝ	Semi/Bi-Monthly:	Semi/Bi-Monthly:	Semi/Bi-Monthly	
Cost to Employer	\$	\$	\$	24 pay periods	24 pay periods 26 pay periods	24 pay periods 26 pay periods	
Cost to Employer Cost to Employee						☐ Zo pay periods	
Cost to Employee	\$		-	26 pay periods			
Cost to Employee Employee + Children				⊠ 26 pay periods			
Cost to Employee Employee + Children Cost to Employer	\$	\$	\$	Monthly:	Monthly:	Monthly:	
Cost to Employee Employee + Children Cost to Employer Cost to Employee				Monthly:	☐ 10 Months	Monthly: 10 Months 12-Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family	\$ \$	\$ \$	\$ \$	Monthly:	Monthly: 10 Months 12-Months	☐ 10 Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family Cost to Employer	\$	\$		Monthly:	☐ 10 Months	☐ 10 Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family	\$ \$	\$ \$	\$ \$	Monthly:	☐ 10 Months	☐ 10 Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family Cost to Employer Cost to Employer Cost to Employee	\$ \$ \$ <mark>631.5</mark> 0 \$ <u>424.</u> 48	\$ \$ \$	\$ \$ \$	Monthly:	☐ 10 Months	☐ 10 Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family Cost to Employer Cost to Employer Cost to Employer Cost to Employee SECTION 5 - EMPLO	\$ \$ \$ <u>637.50</u> \$ <u>434.48</u> OYER'S REPR tative or Benefits to	\$ \$ \$ ESENTATIV	\$ \$ \$	Monthly: 10 Months 12-Months	10 Months 12-Months	☐ 10 Months	
Cost to Employee Employee + Children Cost to Employer Cost to Employee Family Cost to Employer	\$ \$ \$ <u>631.50</u> \$ <u>H3H.</u> 48 DYER'S REPR tative or Benefits h	\$ \$ \$ ESENTATIV	\$ \$ \$	Monthly: 10 Months 12-Months	10 Months 12-Months	☐ 10 Months	



Examples of Insurance Cards

Front Back







Other Supporting Documents (Not Required)

POA

Form POWER OF ATTORNEY BE IT KNOWN: That the undersigned corporation), (a partnership), (a) organized under the laws of _, or (an individual/sole proprietor, a resident of the State of _ hereby irrevocably appoints the Securities Commissioner of Texas, and the Commissioner's successors in office, its attorney in Texas upon whom may be served any notice, process, or pleading in any action or proceeding arising out of any transaction subject to the Texas Securities Act, in accordance with all applicable laws of the State of Texas; and the undersigned hereby agrees that any proceeding against it may be commenced in any court of competent jurisdiction and proper venue within Texas by service of process upon the Securities Commissioner of Texas, and the Commissioner's successors in office, with the same effect as if the undersigned was organized or created under the laws of Texas, or was a resident of Texas, and had been lawfully served with A copy of any notice, process, or pleading served hereunder will be mailed to the undersigned's address of record on file with the Securities Commissioner as of the date of service. This Power of Attorney is made in compliance with the provisions of the Texas Securities Act, Tex. Rev. Civ. Stat. Ann. art. 581-1 et seq ____ day of _____, 2____ (President)(Partner)(Sole Proprietor)(Member)(Strike out inapplicable terminology and fill in blanks, as appropriate. 08-10-2003

Consent Form

CONSENT AUTHORIZATION FORM FOR RELEASE OF INFORMATION

Health Insurance Premium Payment (HIPP) and HIPP For Kids Program

Purpose: Medicaid eligibility is required for participation in the HIPP/HIPP For Kids Program. Authorization for release of Medicaid eligibility information is required by the HIPP/HIPP For Kids Program when the Medicaid eligible family member does not live in the same household as the policyholder or applicant, who has the health insurance coverage, through their employer's sponsored-group plant. This consent form authorizes the Department of Medicaid Assistance Services the right to release information about the Medicaid eligible family member(s) eligibility status to the policyholder/applicant. The person who applied for Medicaid eligibility rhrough their local Department of Social Services must authorize this request since it may become necessary for the HIPP/HIPP For Kids Program to communicate information regarding the eligibility status of a family member, to the policyholder, who is not living in the same household

If the consent form is not signed authorizing release of Medicaid eligibility information, participation in the HIPP/HIPP For Kids Program will be denied.

The consent form must be signed below by the Medicaid eligible family member, if age 18 or older, or by the person who applied for Medicaid eligibility at the local Department of Social Services.

I, (Print name of person who applied for Medicaid) authorize the HIPP/HIPP For Kids Program to release Medicaid eligibility information of the eligible family members listed below to (Print the Policyholder's name) for the purpose of participation in the HIPP For Kids Program. This authorization will remain in effect as long as there is continuous participation in the HIPP/HIPP For Kids Program. Any break in participation will require a new signed consent form.

Signature of Person Consent:	a Authorizing	
Relationship to Med	licaid Family Member:	

(Reference: Chapter 2, Page 1, Section 2: HIPP Policy Manual)



You are Ready to start your application!

Let's Go!

- We hope the examples were helpful, and as you go through the steps of completing your application please be sure to:
 - 1. Provide accurate information
 - 2. Check for misspelling's
 - Call the HIPP Unit if you have any questions regarding the submission of your application
 - Please keep track of your application ID number that is provided



Starting Your HIPP Application: 1st Visit the DMAS webpage at: www.dmas.virginia.gov

Click on the "Programs & Services" option located on the left hand side of the screen, once you have clicked on the link a drop down will appear, and you will have the ability to select the 'HIPP" option. Please click on the "HIPP" link once it is displayed.





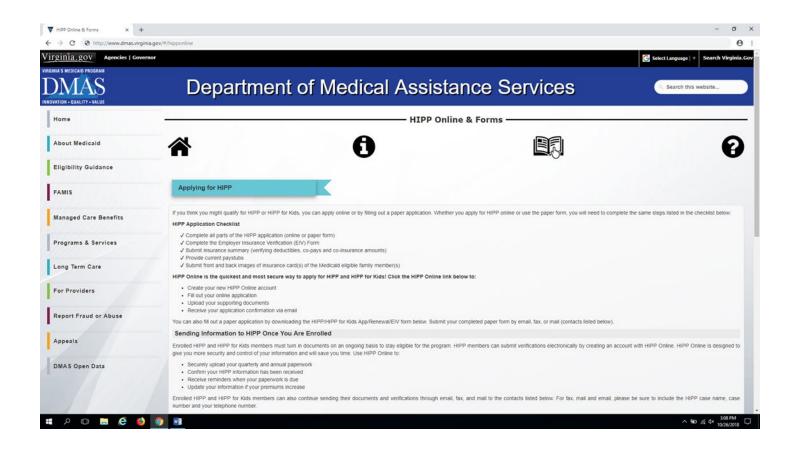
Navigating the DMAS website

Once you have arrived at Department Of Medical Assistance Services page, your screen should look like the screenshot below



Step 1 continued......

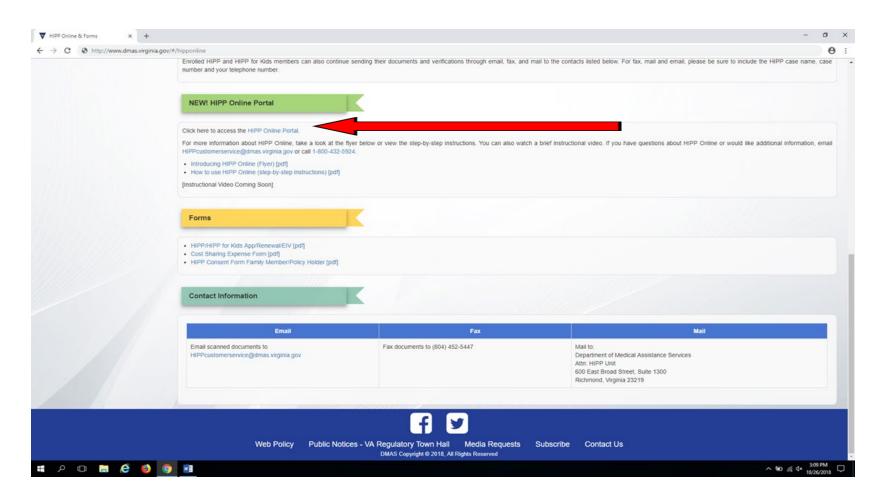
The top of the webpage should resemble the screenshot below





Step 1: Select the HIPP Online Application

As you scroll to the bottom portion of your screen, you will select the option highlighted below





Step 2

From the HIPP Application link, the user is navigated to the new HIPP User Selection Screen.





NEW USERS

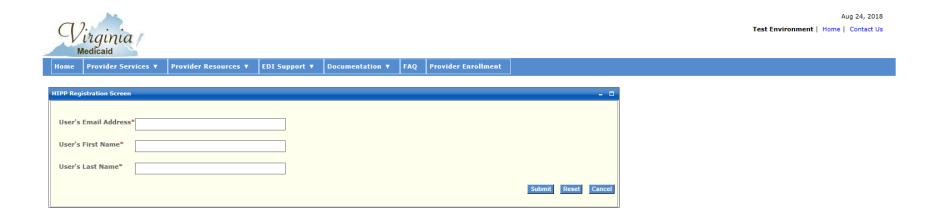
First time users will need to register for REDCap by clicking the 'First Time User' link highlighted in red below





Step 3

New users are navigated to the HIPP Registration Screen where they'll enter the following information:



Your User Name will be your email address

User's will enter their email address and their first and last name, followed by clicking 'Submit' highlighted in red below





Creating your password

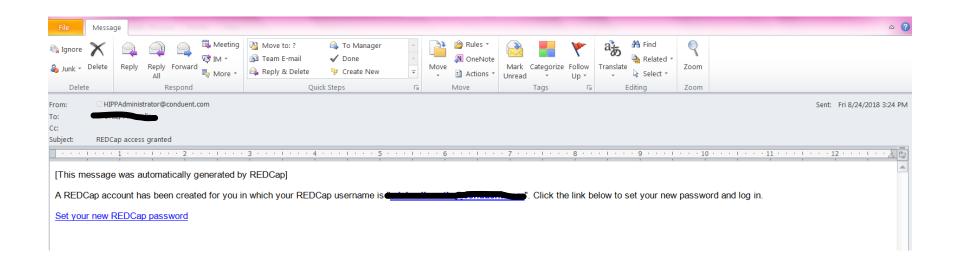
User will receive a message that an ID was created and an email generated to create a password , which is written in red below

Wirginia Medicaid	Aug 24, 2018 Test Environment Home Contact Us
Home Provider Services ▼ Provider Resources ▼ EDI Support ▼ Documentation ▼ FAQ Provider Enrollment	
User's Email Address* User's First Name*	
User's Last Name* Submit Reset Cancel	



Email to Create Password

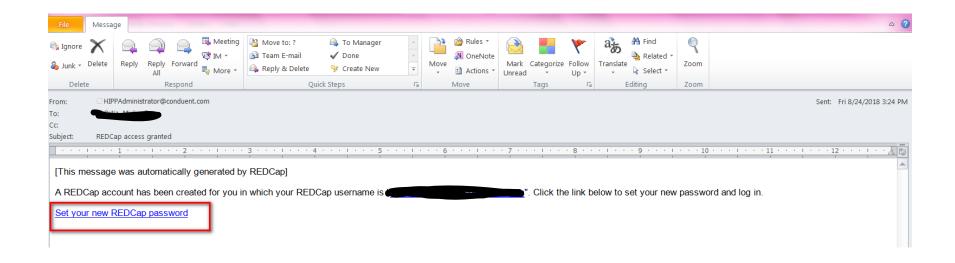
The email that the user will receive, will be formatted like the screen shot below. The email will also reference the User email address as well:





Link to Red Cap

From the email, the user will click on the link to create password highlighted in red below



Red Cap

The password link will open the following screen below with the user name pre-populated:



Set Your Password

Your password has not been set yet or has been reset. You will need to set your password here to whatever value you wish. Please enter your desired password below and click the 'Submit' button. Once your password has been set, you may use it with your username whenever you log in to REDCap. Please make sure that you write down or remember your new password for future use.

The new password entered must be AT LEAST 9 CHARACTERS IN LENGTH and must consist of AT LEAST one lower-case letter, one upper-case letter, and one number.

Username:	@conduent	t.com
Password:		
Re-type password:		
	Submit	

REDCap 7.4.5 - © 2018 Vanderbilt University



Setting up you password

The user will need to create a password, then re-enter it and click 'Submit' highlighted in red below



Set Your Password

Your password has not been set yet or has been reset. You will need to set your password here to whatever value you wish. Please enter your desired password below and click the 'Submit' button. Once your password has been set, you may use it with your username whenever you log in to REDCap. Please make sure that you write down or remember your new password for future use.

The new password entered must be AT LEAST 9 CHARACTERS IN LENGTH and must consist of AT LEAST one lower-case letter, one upper-case letter, and one number.

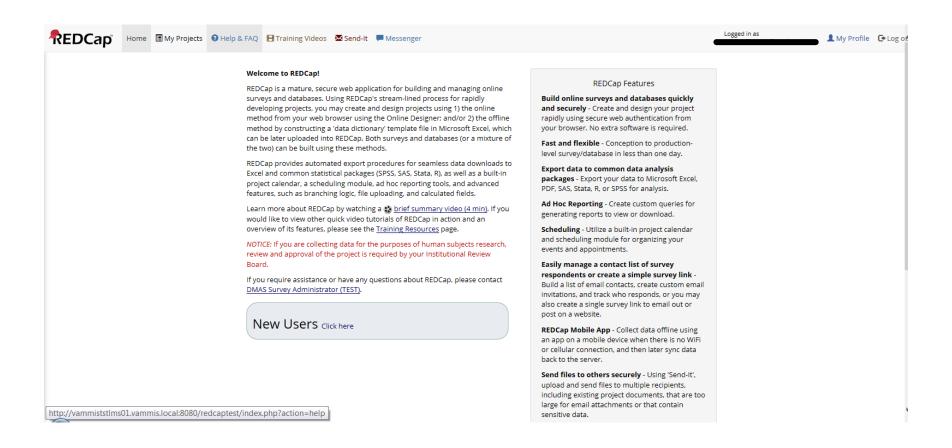


REDCap 7.4.5 - © 2018 Vanderbilt University



After creating your password

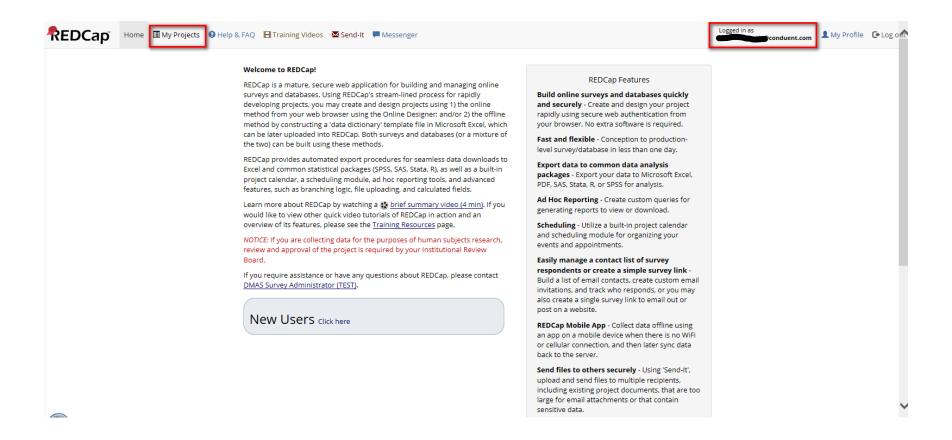
The user will be navigated to the REDCap survey tool





My Projects

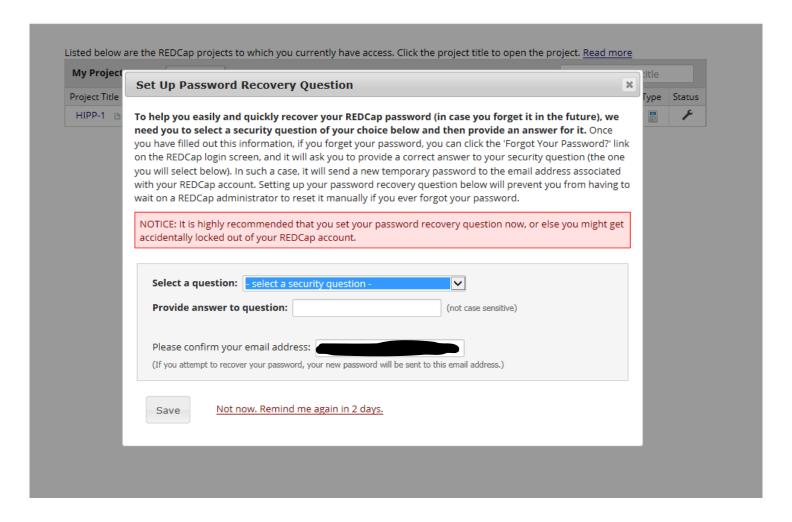
From this screen, the user should confirm they are logged in (user email displays) and click 'My Projects' highlighted in red below, on the left side of the screen





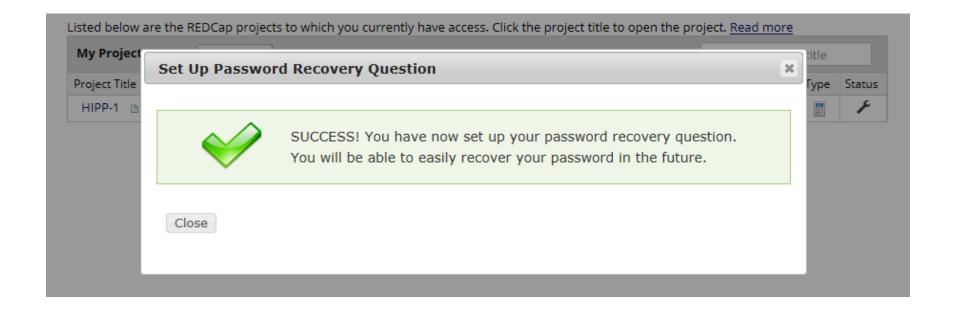
Step 4: Setting your security question

First time users will receive the prompt for a security question. This is only done at registration. Once completed the user is navigated to the REDCap HIPP application survey.



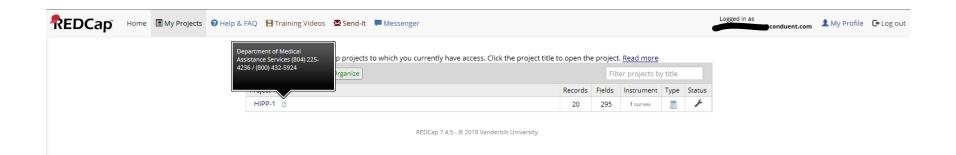
All Set!

The user will select a question and supply an answer and click 'Save', upon which they will receive a successful message. Click 'Close':



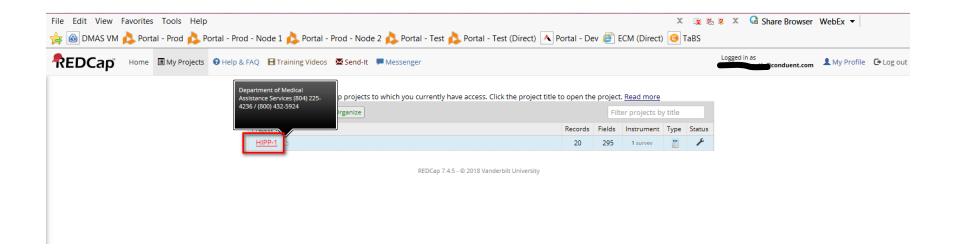
Step 5

After closing the message, the user is routed to the "HIPP-1" Project Screen.



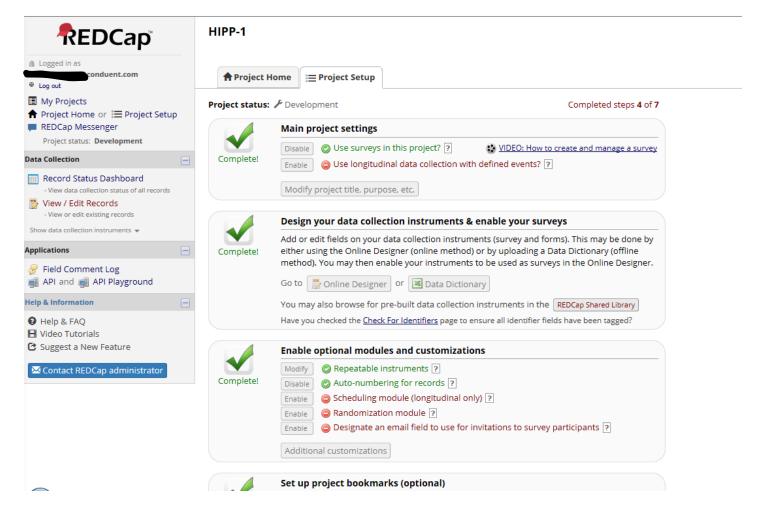
Hover over the Link

Hover over HIPP-1 to see the link and click to open the application highlighted in red below



Getting Started on the Application

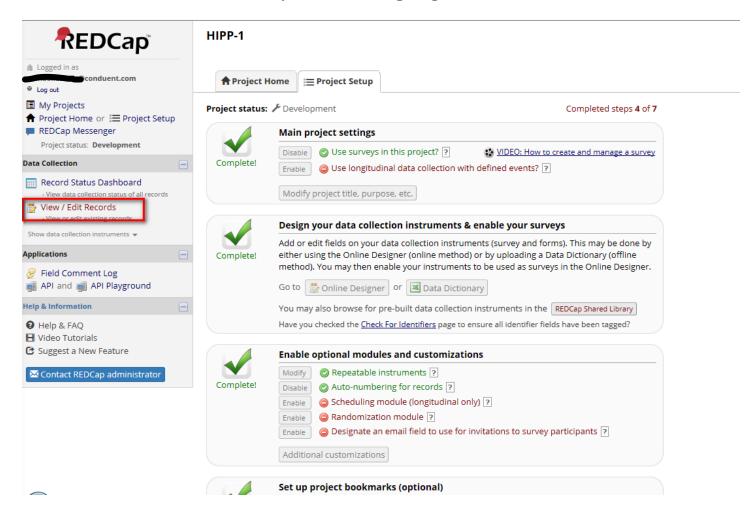
The REDCap project page will display





Step 6

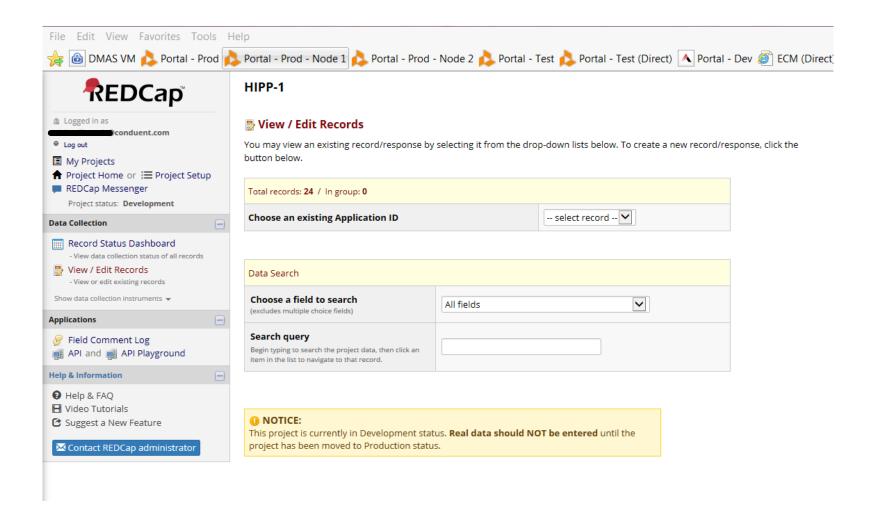
Click the 'View/Edit Records' option from the Data Collection portlet on the left side of the screen, and under the REDCap Section highlighted in red below



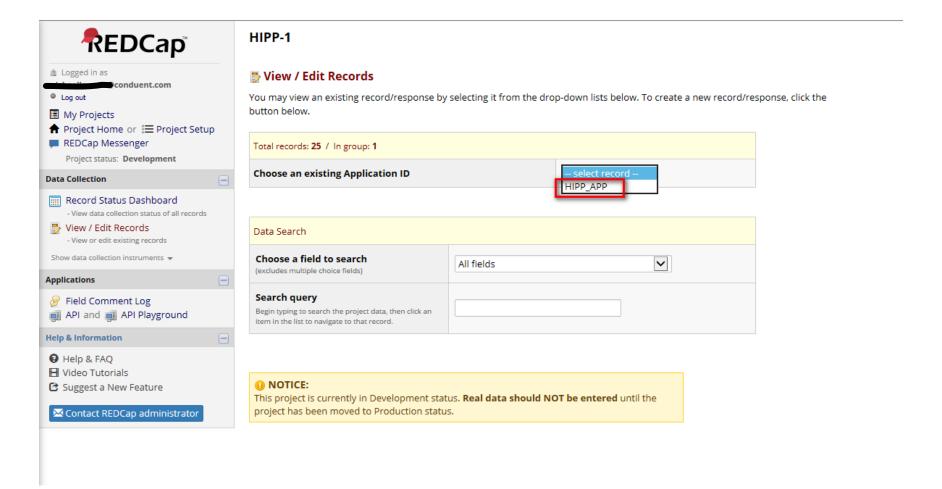


Step 7

The user will be routed to the REDCap View/Edit Records Screen

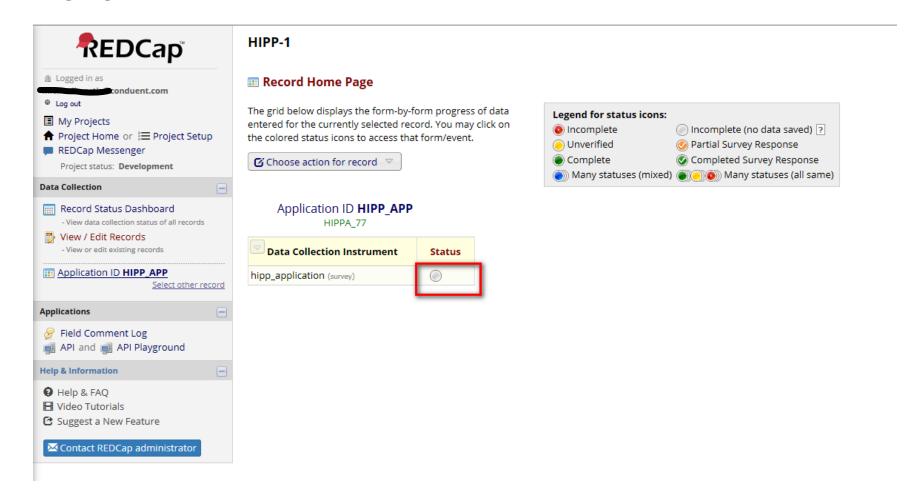


From the 'Choose an existing Application' drop down, the user will see one application listed and select that option. The option name may vary from this screen shot for uniqueness highlighted in red below



Step 8

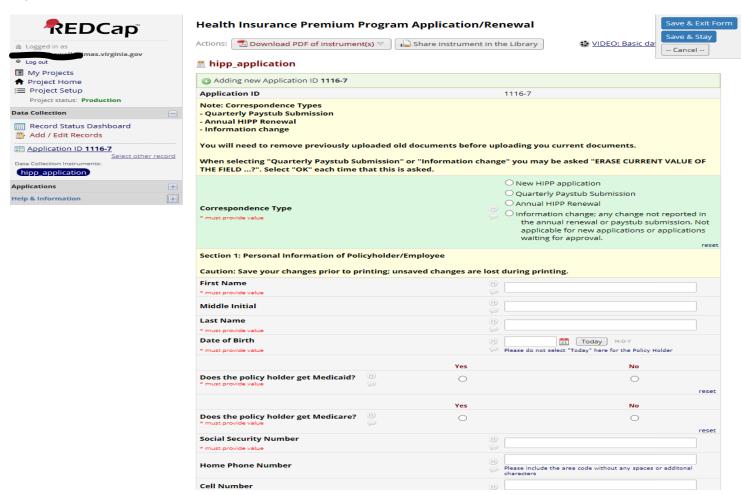
The Record Home Page will open and the user will select the status button highlighted in red below





Step 9: Completing the Application Data Entry Fields

Blank application: Section 1 (screen shots are split for presentation purposes only):

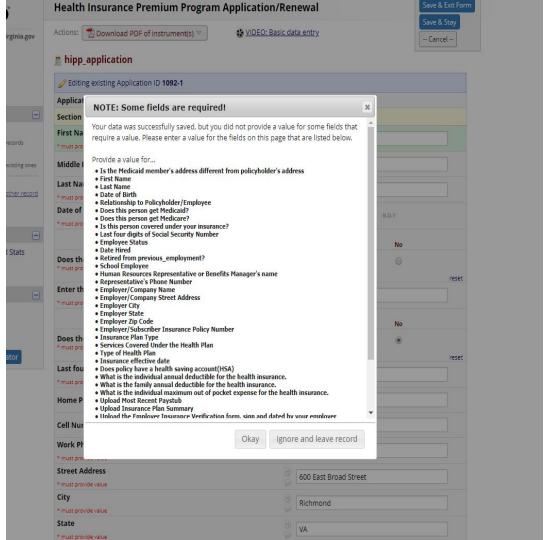




What to expect as you complete your application



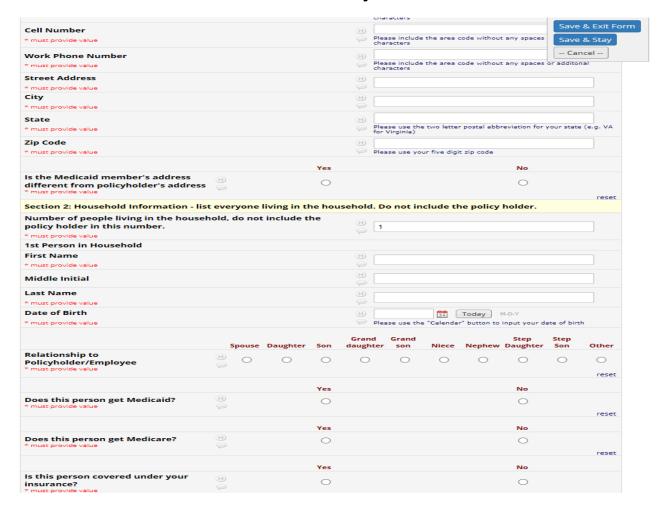
As an application is saved, missing and incomplete items will be identified. The system will alert the applicant of items that should be updated.





Step 9: Continued

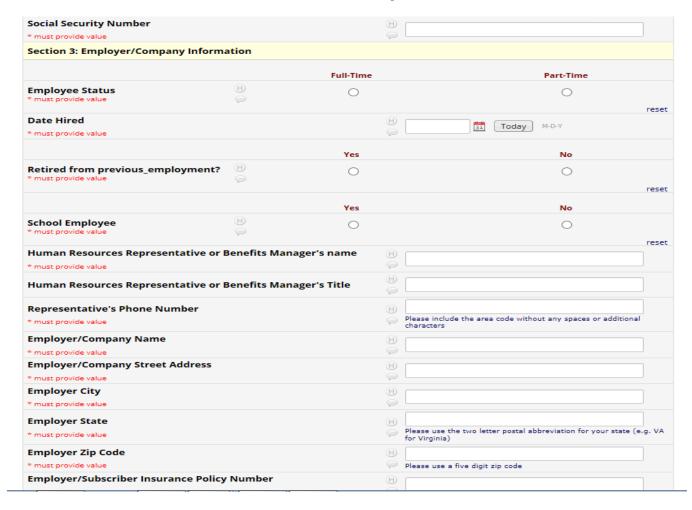
Screen shot of data entry fields below



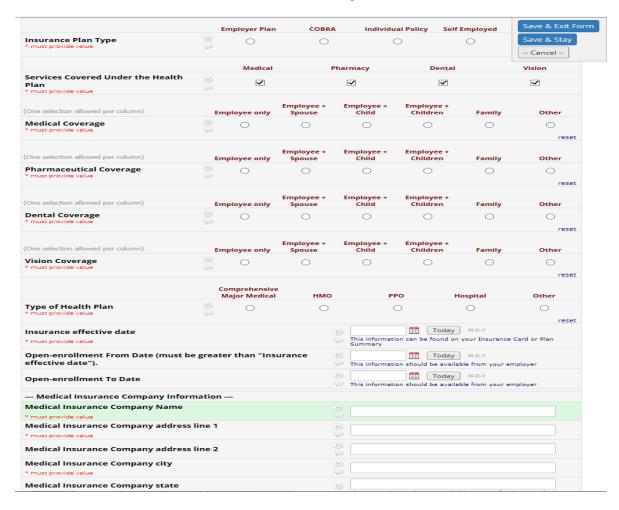


Step 9: Continued

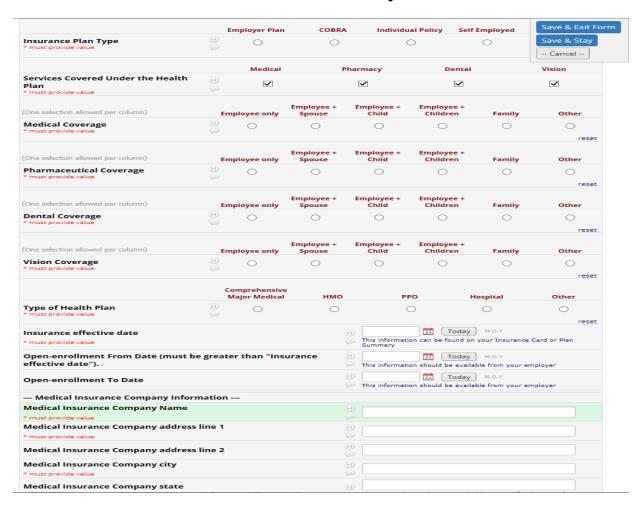
Screen shot of data entry fields below













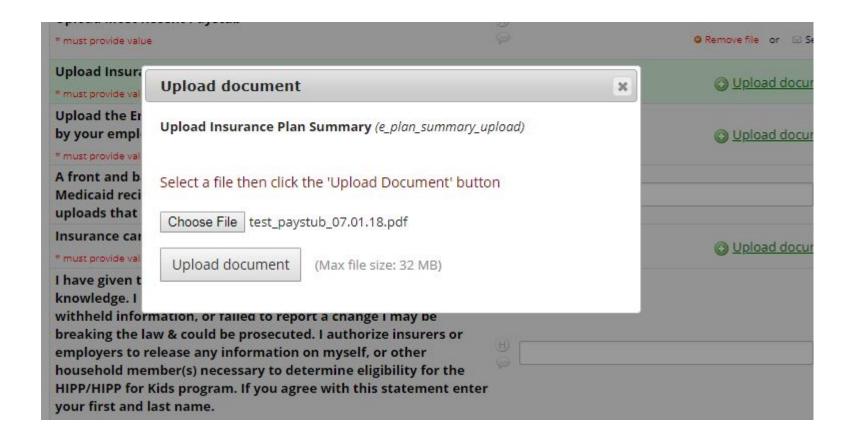
Medical Insurance Company state	\oplus	Please use the two letter postal abbreviation for t	Save & Exit Fo
* must provide value	9	for Virginia)	
Medical Insurance Company zip code	(H)		Save & Stay
* must provide value	9	Please use a five digit zip code	Cancel
Madical Incomes Comments Phone Northern			
Medical Insurance Company Phone Number	(H)	Please include the area code without any spaces	or additional
* must provide value	~	characters	
Medical Insurance Group Number	\oplus		
* must provide value	9	This information can be found on your insurance	card
Mardinal Incomes Paline Number	\oplus		
Medical Insurance Policy Number	9	This information can be found on your insurance	card
Yes		No	
Does policy have a health saving		0	
account(HSA) * must provide value			
			reset
What is the individual annual deductible for the health insurance.	(H)		
* must provide value	9	This information can be found on your plan summ	nary
What is the family annual deductible for the health insurance.	\oplus		
f must provide value	9	This information can be found on your plan summ	nary
What is the individual maximum out of pocket expense for the	(H)		
health insurance.	0	This information can be found on your plan summ	
must provide value		This information can be round on your plan summ	iaiy
What is the family maximum out of pocket expense for the health	\oplus		
insurance.	9	This information can be found on your plan summ	nary
Pharmaceutical Insurance Company Information			
Pharmacy Insurance Company Name	(H)		
* must provide value	9		
Pharmacy Insurance Company address line 1	(H)		
(address is not required; enter if available)	9		
	(H)		
Pharmacy Insurance Company address line 2	9		
	(H)		
Pharmacy Insurance Company city	9		
	(H)		
Pharmacy Insurance Company state		Please use the two letter postal abbreviation for t	he state (e.g. VA
		for Virginia)	
Pharmacy Insurance Company zip code			
,,	9	Please use a five digit zip code	
Pharmacy Insurance Company Phone Number	(H)		
must provide value	0	Please include the area code without any spaces characters	or additional
		cnaracters	
Pharmacy Insurance Group Number	H)		
must provide value	9		
Pharmacy Insurance Policy Number	(H)		
	9		
Dental Insurance Company Information			
Dental Insurance Company Name	\oplus		
k must provide value	9		
Dental Insurance Company address line 1	\oplus		



Uploading Documents

Do you have other supporting documents to upload (Examples: Power Of Attorney, Custody Order, Executor)?		0	
yes		No	
* must provide value	9	① <u>Upload document</u>	
Insurance card 1 upload	\oplus	@ Unland dansarat	
A front and back image of each unique insurance card is require; Medicaid recipients only . Enter the number of insurance card uploads that will be needed.	H (Please be certain that all of the documents are clearly legible, as poor quality images may not be accepted.	
Upload the Employer Insurance Verification form, sign and dated by your employer * must provide value	H	Upload document Please be sure that both pages of the EIV form are completed according to the instuctions.	
Upload Insurance Plan Summary * must provide value	H •	This must provide information about your deductibles, co-pays, and the services covered by your insurance. Please be certain that all of the documents are clearly legible, as poor quality images may not be accepted.	
Upload Most Recent Paystub * must provide value	H (p)	Please be certain that the paystub reflects a deduction for the medical insurance premium Please be certain that all of the documents are clearly legible, as poor quality images may not be accepted.	
Dental Insurance Policy Number	H (
Dental Insurance Group Number * must provide value	H		
Dental Insurance Company Phone Number	(H)	Please include the area code without any spaces or additional characters	
Dental Insurance Company zip code	H (====================================	Please use a five digit zip code	
Dental Insurance Company state	(H)	Please use the two letter postal abbreviation for the state (e.g. VA for Virginia)	
Dental Insurance Company city	H		
Dental Insurance Company address line 2	H (
Dental Insurance Company address line 1 (address is not required; enter if available)	(H)		



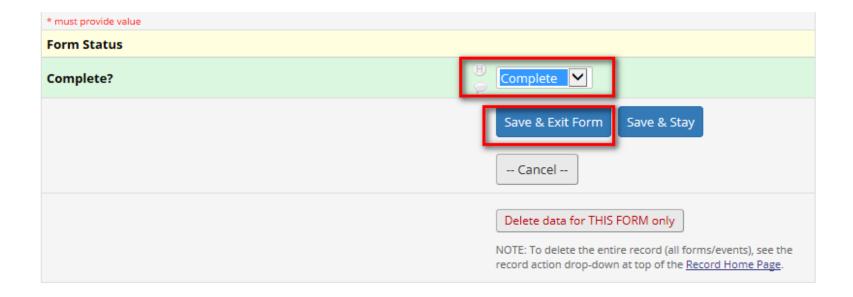




I have given true & accurate information to the best of my knowledge. I understand that if I have given false information, withheld information, or failed to report a change I may be breaking the law & could be prosecuted. I authorize insurers or employers to release any information on myself, or other household member(s) necessary to determine eligibility for the HIPP/HIPP for Kids program. If you agree with this statement enter your first and last name.	H ====================================
I understand that within 24 hours I will receive an email confirmation of my submission. * must provide value	⊕ □Yes
I understand that I must select "Form Status" "Complete" to submit this form to the Virginia Medicaid HIPP unit. * must provide value	⊕ □Yes
Form Status	
Complete?	☐ Incomplete ✓
	Save & Exit Form Save & Stay
	Cancel

Step 10

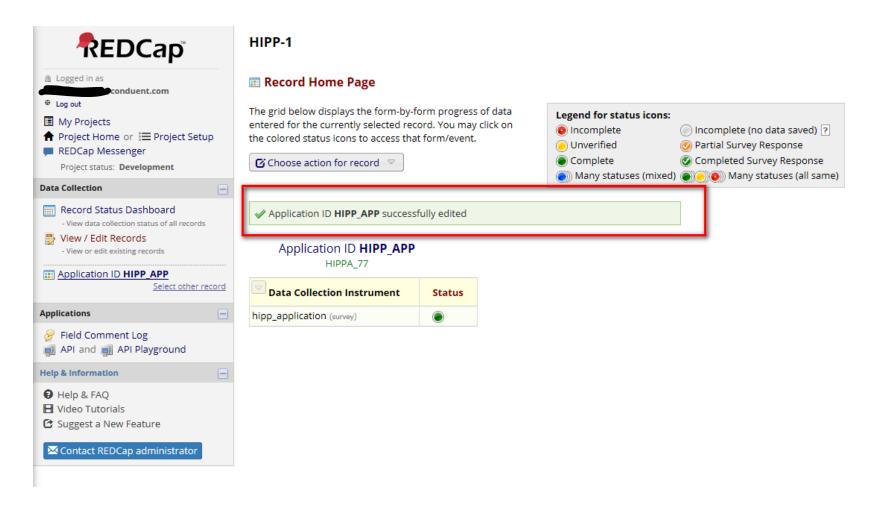
Once a user has completed the application, they will change the complete drop down selection to complete and click 'Save and Exit Form' highlighted in red below





Application Submittal successful

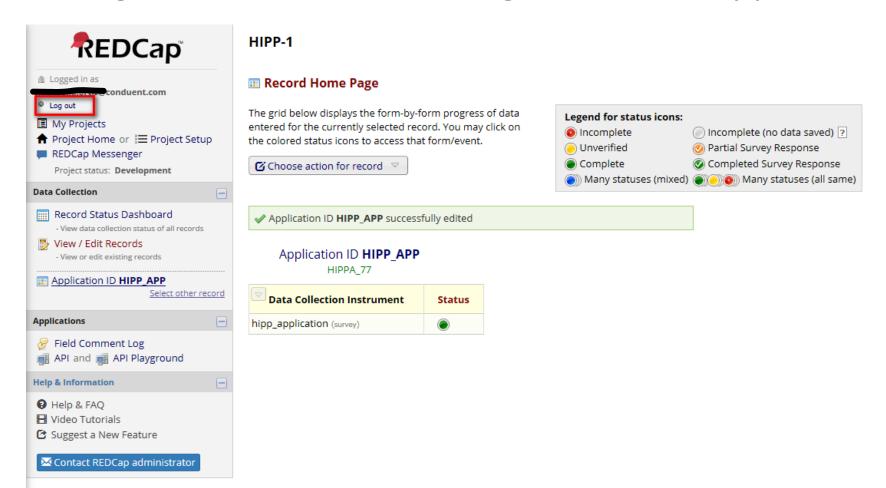
If fields are missed the user will receive notification as to which need to be completed. If submission is successful, the following message will be received.





Logging Out

To log out, the user clicks 'Log Out' in the upper left

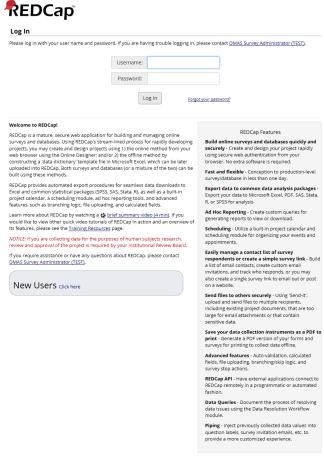




Registered users will click on the 'Registered User' link:



Registered/existing users will be navigated to the REDCap Log In screen:



REDCap 7.4.5 - © 2018 Vanderbilt University



Enter email and password and click 'Log in' highlighted in red below

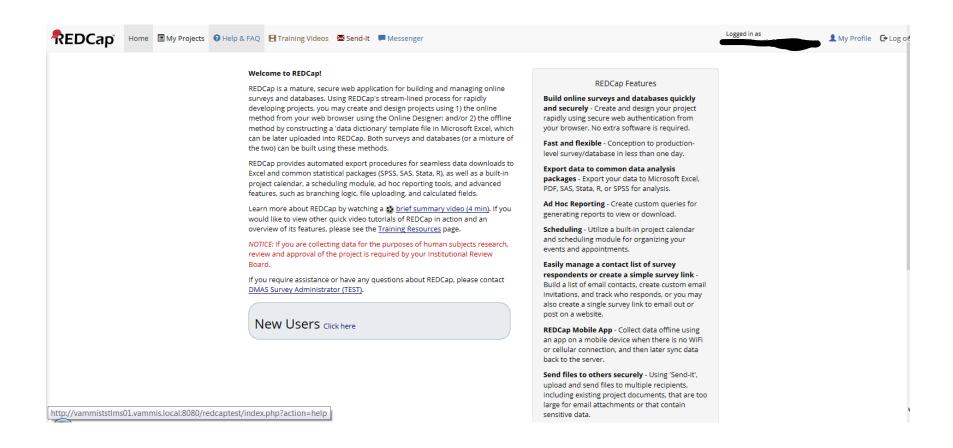




If user forgot password they can click 'Forgot Your Password?' link highlighted in red below

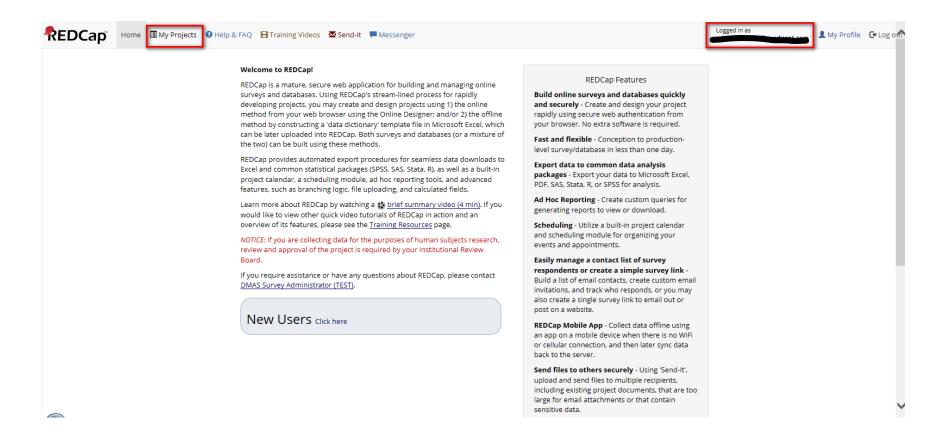
REDCap [™]				
Log In				
Please log in with your user name and p (TEST).	password. If you are having trouble logging in, please contact <u>DMAS Survey Administrator</u>			
	Username:			
	Password:			
	Log In Forgot your password?			
Welcome to REDCap!				

After logging in , the user will be navigated to the REDCap survey tool



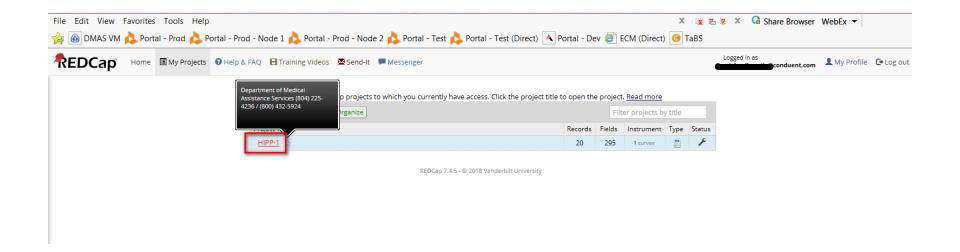


From this screen, the user should confirm they are logged in (user email displays) and click 'My Projects' highlighted in red below

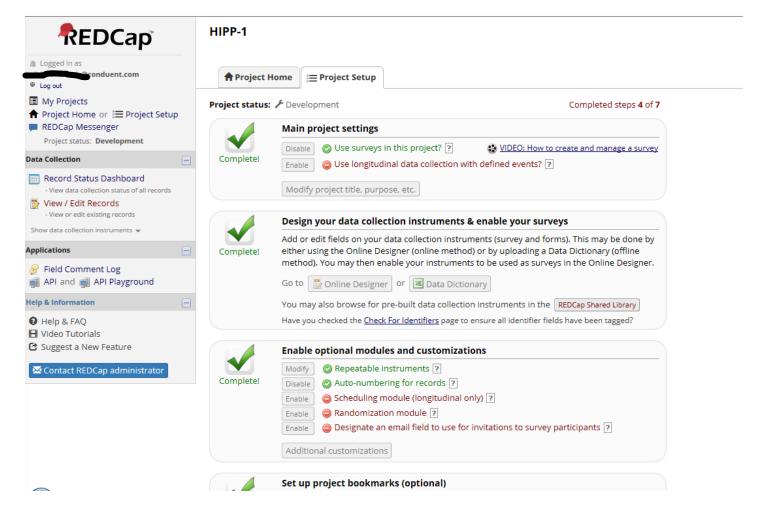




Hover over "HIPP-1" to see the link and click to open the application highlighted in red below

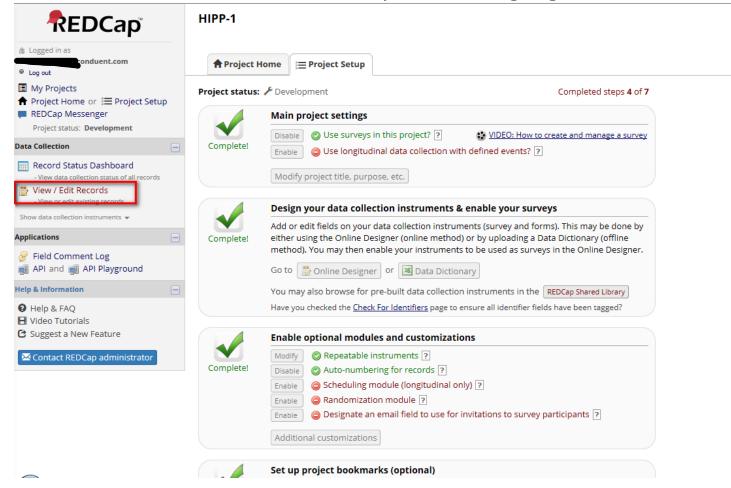


The REDCap project page will display



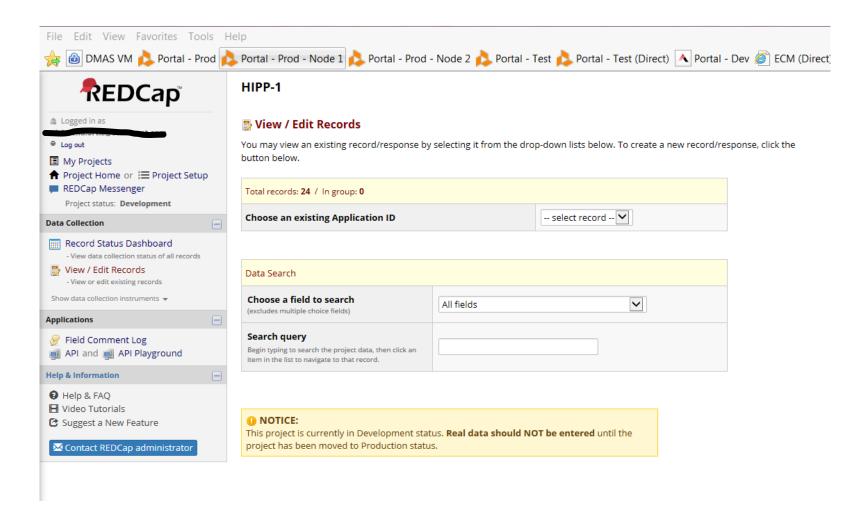


Click the 'View/Edit Records' option from the Data Collection portlet on the left side of the screen, under the REDCap Section highlighted in red below



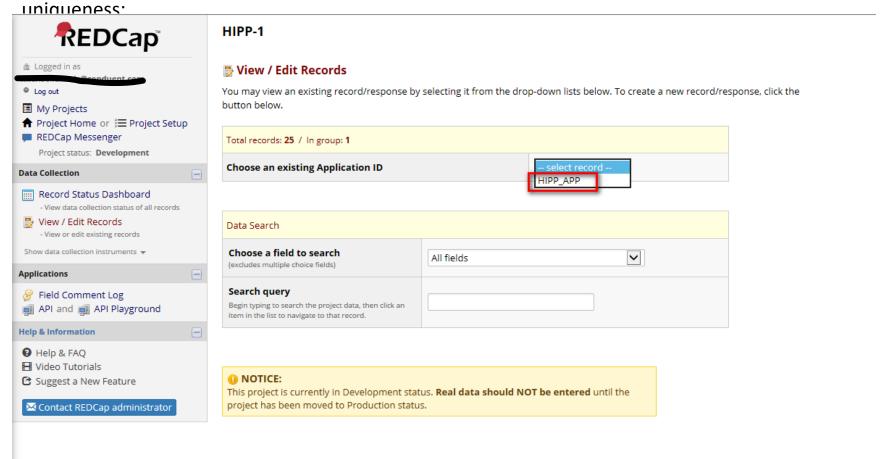


The user will be routed to the REDCap View/Edit Records Screen



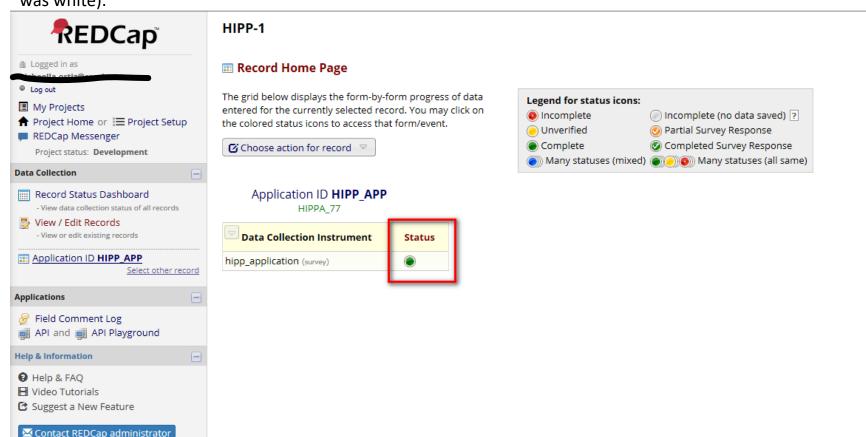


From the 'Choose an existing Application' drop down highlighted in red below, the user will see one application listed and select that option. The option name may vary from this screen shot for



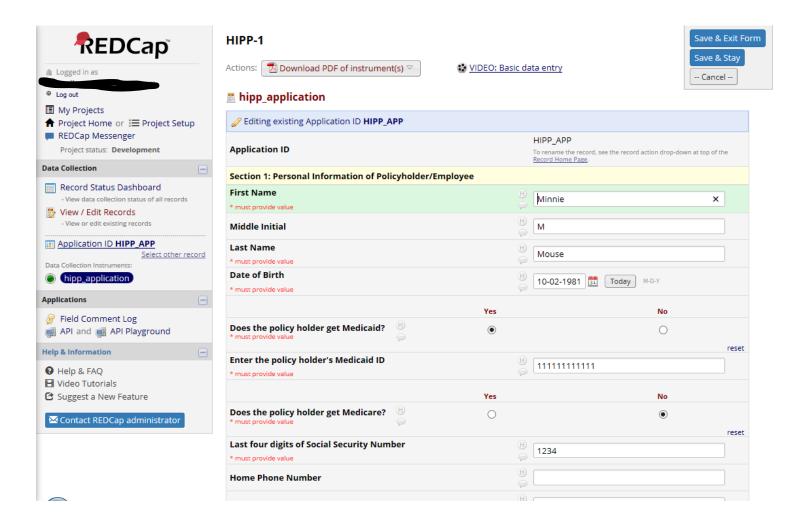


The Record Home Page will open and the user will select the status button highlighted in red below (Notice that the status button is now green as the application is submitted where initially, as a newly registered user it was white):



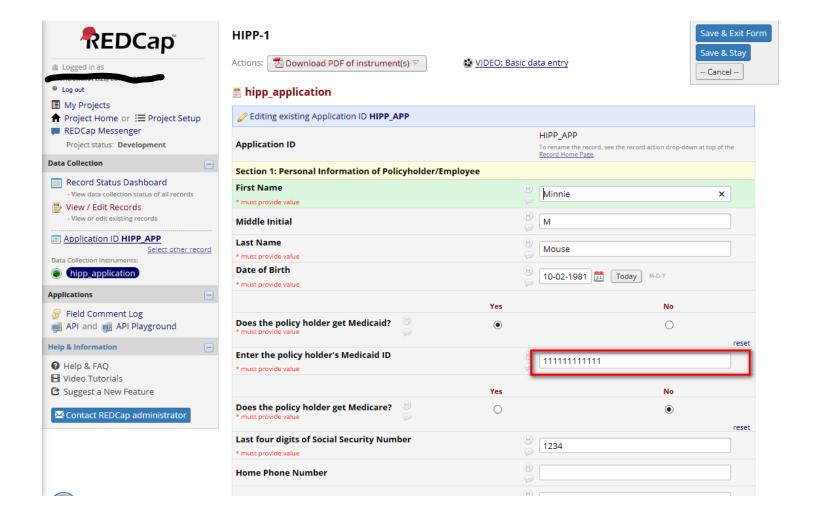


User's existing record is retrieved and displayed and allows for editing:



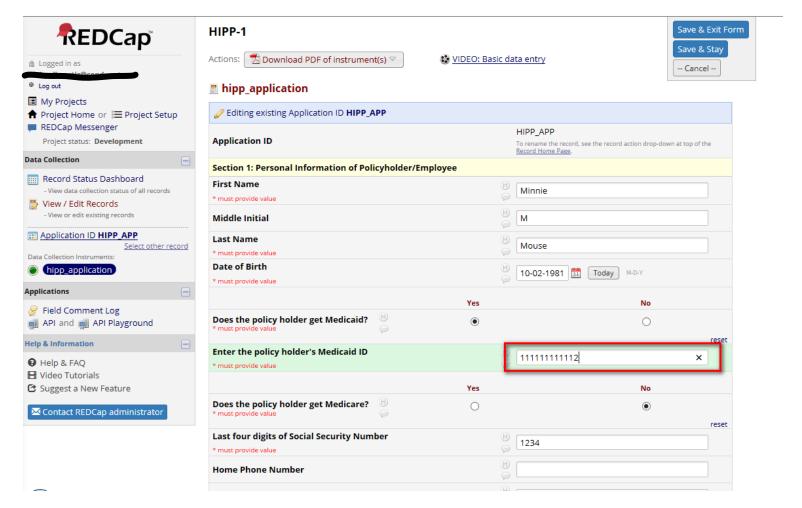


Continued from the previous slide (highlighted in red below)



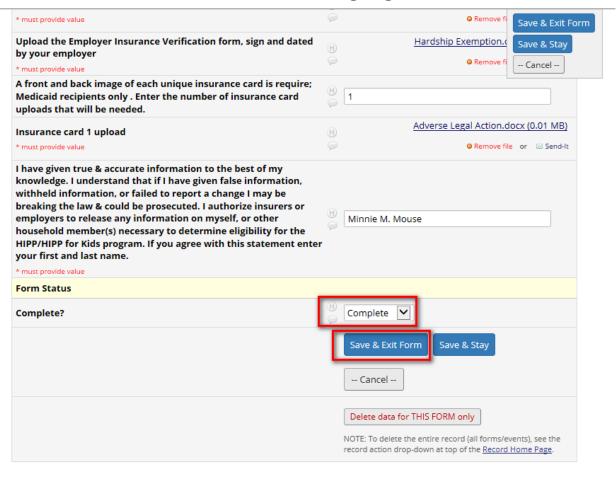


Change ID number highlighted in red below





After all updates are made, user will make sure that the Complete drop down option is still 'Complete' and then click 'Save & Exit Form' highlighted in red below



If changes clear the edits, the user will receive a successful edit message and can log out, highlighted in red below





COMPLETED APPLICATION!

- What to expect next
 - ☐ Up to 45 days processing time
 - ☐ You will receive a written confirmation of your approval or denial to the program
 - ☐ If approved for the program you will receive information on the next steps as a HIPP member



Questions

Please contact the HIPP unit with any question

HIPP HIPP Unit Contact Information:
600 East Broad Street, 12th Floor
Richmond, VA 23219
(804) 225 – 4236
(800) 432 – 5924 (Virginia Residents)

http://dmasva.dmas.virginia.gov/Content-pgs/rcphipp





