Health Insurance Premium Payment (HIPP) Program

STATEMENT OF DIAGNOSIS MEDICAL REPORT

TELL US ABOUT YOUR MEDICAL CONDITION(S) *(required)*

Complete all items. Incomplete forms will be returned causing delay in HIPP benefits. Attach a separate Statement of Medical Report form for each family member listed on your insurance policy with a medical condition.

The HIPP Program applicant/beneficiary, or parent/guardian acting on his or her behalf, is to complete the information requested in PARTS A and B prior to giving the form to the physician for completion of PARTS C and D.

PART A: Applicant/Beneficiary Information

NAME *(last, first, middle)*:	**HIPP CASE ID NUMBER:**
ADDRESS *(street, city, state, zip code)*:	
DAYTIME TELEPHONE NUMBER: ( )	**DATE OF BIRTH:**

PART B: Authorization

I hereby authorize my attending physician _____ to furnish and disclose all facts concerning my medical condition that are within his or her knowledge and to allow inspection, and provide copies of any medical records concerning my medical condition that are under his or her control, with the exception of psychotherapy notes. This authorization does not authorize the release of any psychotherapy notes. This information will be used to determine my eligibility for the HIPP Program. This authorization shall be valid for a period of one (1) year from the date of my signature or until I am no longer eligible for the HIPP Program, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, HIPP may not be able to determine my eligibility for the program and my application may be denied or my eligibility may be terminated. I understand that I can revoke this authorization in writing, unless the Department of Health Care Services or the HIPP Program have taken action in reliance upon this authorization, or the authorization is a condition of obtaining insurance coverage and the insurer has the right to contest the policy itself or a claim under the policy.

I also understand that the HIPP Program will keep confidential all of the information which is provided pursuant to this authorization, and that the information will be used solely to determine my eligibility for the HIPP Program.

_____ _____

SIGNATURE OF HIPP APPLICANT/BENEFICIARY OR PARENT/GUARDIAN **DATE SIGNED**

_____ _____

PRINT NAME OF HIPP APPLICANT/BENEFICIARY OR PARENT/GUARDIAN **RELATIONSHIP TO APPLICANT/BENEFICIARY**

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ATTENDING PHYSICIAN IS TO COMPLETE ALL REQUESTED INFORMATION IN PARTS C AND D
All responses must be legible.

Please DO NOT send information copied directly from the patient's medical record at this time.

PART C: Statement of Diagnosis Medical Report

DIAGNOSIS MEDICAL REPORT	
Diagnosis *(required):*	
ICD Code, Primary *(required):*	Additional ICD Code(s):

PLEASE NOTE:

- For mental retardation, please state if mild **OR** moderate to profound.
- For diabetes, please state if insulin dependent or not.
- For surgeries, please state date of each surgery.

PART D: Certification of Medical Condition

I certify that, based upon my examination of the patient, the above statements describe the patient's medical condition and that I am a _____, _____
(type of physician) *(specialty, if any)*

licensed to practice by the State of _____.

PHYSICIAN'S SIGNATURE:	DATE:
PHYSICIAN'S NAME *(as shown on license – please print):*	STATE LICENSE NUMBER:
TELEPHONE NUMBER: ( )	FAX NUMBER: ( )
ADDRESS *(street, city, state, zip code):*	

Under the provisions of the California Welfare and Institutions Code, Section 14100.2, any information gathered is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes. Under the provisions of the Federal Privacy Act, this authorization may be revoked. Information disclosed may be subject to re-disclosure by the Department of Health Care Services and no longer protected by the Federal Privacy Act. This authorization is valid for one (1) year from the date of signature.