Clear Form Data
FILLABLE FORM

DHS-2841-ENG 3-09

Minnesota Department of **Human Services**

Minnesota Health Care Programs (MHCP)

Cost Effective Insurance Referral Employer or Insurance Company Form

CLIENT NAME (LAST, FIRST, MI)	CLIENT CASE NUMBER

I give permission to my employer/union (or former employer), or insurance company named below to release the requested information to the agency(s) listed on this form. This information is used to figure my eligibility for medical assistance. This authorization will end one year from the date I sign it.

CLIENT SIGNATURE	DATE

EMPLOYER NAME	EMPLOYER CONTACT PERSON

EMPLOYED	☐ Y	☐ N	MEDICAL LEAVE	☐ Y	☐ N	EXPECTED DATE OF RETURN TO WORK
TERMINATED	☐ Y	☐ N	RETIRED	☐ Y	☐ N	

Insurance Information

INSURANCE COMPANY NAME	POLICY HOLDER (INSURED PERSON) NAME (LAST, FIRST, MI)	POLICY BEGIN DATE

Premium Amounts

If client does not pay monthly health insurance premiums, calculate monthly amounts as follows:

Paid weekly: weekly premium	$ _____ X 52 = $ _____ ÷12 =	$
Paid bi-weekly: bi-weekly premium	$ _____ X 26 = $ _____ ÷12 =	$
Paid twice monthly: bi-monthly premium	$ _____ X 24 = $ _____ ÷12 =	$

MONTHLY PREMIUM COST FOR ALL	NUMBER OF PEOPLE COVERED BY POLICY
$	

Policy Information

Check the box(es) that relate to the health insurance policy coverage.

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LTC ☐ LIMITED BENEFITS ☐ OTHER ☐ HSA $_____ ☐ HRA/MSA (Amount) $_____

IN NETWORK DEDUCTIBLE		OUT-OF-NETWORK DEDUCTIBLE		CO-INSURANCE IN-NETWORK	CO-INSURANCE OUT-OF-NETWORK
PER PERSON	FAMILY	PER PERSON	FAMILY		
$	$	$	$	$	$
PRESCRIPTION COPAY		ANY ANNUAL LIMIT		YEARLY OUT-OF-POCKET MAX AMOUNT	LIFETIME MAX AMOUNT
GENERIC	BRAND				
$	$	$		$	$

Fax or mail form to the county worker. If you have any questions, contact the county worker.

COUNTY NAME	WORKER NAME	PHONE NUMBER	FAX NUMBER
		( )	( )

COUNTY ADDRESS (if unable to fax)	CITY	STATE	ZIP CODE