HMAP Premium & Copayment Assistance Program (PCAP)Form

Send Form Electronically: PCAPapplications@dhhs.nc.gov

(***Preferred Method of Receipt*** **by Secure Email ONLY**)

Or

Fax: (919) 715 – 2993 **(Via Secure FAX ONLY)**

This form is used to confirm client information for PCAP and ACA enrollment. **A new form is required for ALL PCAP clients during the Annual Enrollment Period and Special Enrollment Period. REMEMBER TO INCLUDE ALL REQUIRED INFORMATION AS IT WAS REPORTED TO THE MARKETPLACE AT TIME OF ENROLLMENT.**

The PCAP Program will not be able to provide any insurance premium payments if the information provided on this form is incomplete or does not match exactly with the information on file with the marketplace or Insurance Carrier; this could also result in a pended or denied PCAP application.

□ **All clients must submit a copy of the Marketplace Printout from Healthcare.gov (My Plans and Programs). Document that lists the Insurance Carrier, Base Premium, Premium Tax Credit (Subsidy), You Pay (Monthly Amount Due), Plan Members, Start Date and End Date.**

HMAP Client CASE NUMBER____________________ **Or New to HMAP (Check Here):** ______

Applicant Name: (First Name) ___________________________________ (Last Name) ________________________

ACA Marketplace Insurance Carrier: ___________________

Insurance Enrollment Date (Date Client Enrolled in a Plan): ____/____/_______

Insurance Effective Date (Date Insurance Plan Starts): ____/_____/_____

Account Number (Bright Health and United Health Care ONLY): ____

Health Insurance Plan ID (Located on the ACA Enrollment Documents): ______________________________

Client Insurance Member ID (If available): ____

Monthly Premium Amount: $_____________

Date of Birth (MM/DD/YYYY)	**Social Security Number**

Street Address used on ACA Marketplace Insurance Enrollment: ____ **City:** ________________________ **State:** ______ **Zip Code:** ___________ **Client Phone Number: ( )** ______ - ________	Apartment/Unit #

4/9/21

Additional documentation and information is also required if this application is for a client who currently has an Active Insurance Plan, defined as a plan that has had payments made previously by another source and is active for use by the client prior to applying for premium assistance from PCAP.

□ **Provide a copy of the Insurance ID Card**

□ **Provide a copy of the most recent billing statement/invoice**

□ **Provide information about all previous payments**

Date:	Amount Paid:	Payment Made By:

□ **Is there an outstanding balance?** □ **Yes** □ **No** □ **Unknown**

If Yes, Amount Due ______________________

If Yes, Due Date _________________________

□ **Has the Autopay feature been used previously?** □ **Yes** □ **No**

If yes, has the Autopay feature been turned off? □ **Yes** □ **No**

[Please note that if the Autopay feature is on the payments will be drafted from the client's account and PCAP will not be able to make payments while this feature is on]