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DEPARTMENT OF BANKING AND INSURANCE
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STEVEN M. GOLDMAN
Commissioner

BULLETIN NO. 07-17

TO: **ALL NEW JERSEY HEALTH INSURANCE COMPANIES; HOSPITAL SERVICE CORPORATIONS; MEDICAL SERVICE CORPORATIONS; HEALTH SERVICE CORPORATIONS; HEALTH MAINTENANCE ORGANIZATIONS; DENTAL SERVICE CORPORATIONS; DENTAL PLAN ORGANIZATIONS; PREPAID PRESCRIPTION SERVICE ORGANIZATIONS; ORGANIZED DELIVERY SYSTEMS; AND OTHER INTERESTED PARTIES**

FROM: **STEVEN M. GOLDMAN, COMMISSIONER**

RE: **AMENDMENTS TO THE HINT FORMS**

On March 26, 2007 the Department issued Bulletin No. 07-07, which addressed amendments to the HINT Enrollment Forms, Exhibits 1A and 1B of the Appendix to N.J.A.C. 11:22-3 (Electronic Transmission and Receipt of Health Care Claims - "HINT" Enrollment forms"). It has come to the Department's attention that the forms in Exhibits 1A and 1B as attached to Bulletin 07-07 do not include the "LOC #s" under the "Activity" section for the "Primary," "OB/GYN" or "Dentist" entries. Therefore the Department is providing as attachments hereto the corrected form pages that now include spaces for the entry of the "LOC #" information. These forms can be accessed via the Department's website at: http://www.state.nj.us/dobi/bulletin.shtml. The Department intends to propose amendments to Exhibits 1A and 1B of N.J.A.C. 11:22-3 to codify the revised forms in the near future.

8/29/07
Date

/s/ Steven M. Goldman
Steven M. Goldman
Commissioner

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B. [Employee] Information – to be completed by the [Employee]	Name (Last, First, MI):	SSN:

Home

Street/Apt:_____
Street/Apt:_____
City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy): ☐ Male ☐ Female

Phone: (_____)_____
[Email: _____]

Work

[Employer] Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____

Phone: (_____)_____
[Email:
_____]
Employment Date: _____/_____/_____
Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

[Primary LOC #:] _____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

[Ob/Gyn LOC #:] _____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

[Dentist LOC #:] _____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

Other Health Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:

[Other Rx Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:]

Previous Coverage? ☐ Yes ☐ No
If Yes:
Effective date: _____/_____/_____ Termination date: _____/_____/_____

Payer Name:_____
Policy #:_____
[*Submit a Certificate of Creditable Coverage*]

C. Plan Option – to be completed by the [Employee] *Check one [Plan Name] [and] [Copay] [and] [or] [Deductible] [and] [or] [Coverage Status]*

D. Other Individuals Covered – to be completed by the [Employee] *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. [Attach proof if full-time post-secondary student.] [Attach proof of disability.]*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue

NONGROUP ENROLLMENT/CHANGE REQUEST

[Carrier Logo]

[Carrier Name]

A. Type of Activity – to be completed by [Applicant] *Refer to instructions [on back] before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Reason
ADD	☐ Enrollment of a new [Insured/Enrollee/Subscriber]	_____/_____/_____	_____
	☐ Add Spouse[/Civil Union Partner]	_____/_____/_____	_____
	[☐ Add Civil Union Partner]	[_____/_____/_____]	[_____]
	☐ Add Domestic Partner	_____/_____/_____	_____
	☐ Add Dependent Child	_____/_____/_____	_____
REMOVE	☐ Remove [Insured/Enrollee/Subscriber]	_____/_____/_____	_____
	☐ Remove Spouse[/Civil Union Partner]	_____/_____/_____	_____
	[☐ Remove Civil Union Partner]	[_____/_____/____]	[_____]
	☐ Remove Domestic Partner	_____/_____/_____	_____
	☐ Remove Dependent Child	_____/_____/_____	_____
OTHER CHANGE	☐ Name Change	_____/_____/_____	_____
	☐ Change Plan	_____/_____/_____	_____
	☐ Other	_____/_____/_____	_____
	☐ [Add/Change Office ID Numbers: Primary/OB/Gyn]	_____/_____/_____	_____

B. [Applicant] Information Name (Last, First, MI):

SSN: | Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female | [Email:]

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state? ☐ Yes ☐ No *If yes:*
Name of State:_____ Number of months you live there each year: _____

Address Information

Primary Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Other Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

Activity

☐ Add ☐ Remove ☐ Other Change ☐ Continue *If a name change, indicate prior name:*

[Primary LOC#:] _____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address: zip+4]

[Ob/Gyn LOC#:) _____ [NPI #:] [Current Patient: ☐ Yes ☐ No]
address:] zip+4