

Application for Waiver or Reduction of MassHealth Premium

For office use only
Log no.:
Customer account #:
Date received:

	Please provide information below about the event hardship, and return this form by		e that led to yo	ur extreme financial to		
	r					
	MassHealth Customer Service, Attn: Premium Billing, P.O. Box 120049, Boston, MA 02112.					
	If your income has changed, please call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).					
	This form should have a unique log number and a pre-filled re at 1-800-841-2900 (TTY: 1-800-497-4648 for people with par			issHealth Customer Service		
Aŗ	plicant information					
	Last name First name			Middle initial		
	Social security no.	Phone no.				
	Street address					
	City	State	Zip			
De	tails of hardship					
	Please check any and all of the boxes below that relate to your or your family's extreme financial hardship. I am homeless, or am more than 30 days behind in rent or mortgage payments, or have received an eviction or foreclosure notice. I have a shut-off notice from my utility company (gas, electric, oil, water, or telephone), or one or more of my utilities has been shut off, or one or more of my utility companies is refusing to deliver services because I cannot pay. (If you have a large or long overdue utility bill, but you are protected from shutoff because you are disabled or because it is winter, check this section.) I have high medical and/or dental bills that MassHealth or another insurance does not pay for. These bills may be for me or for someone else in my immediate family (such as a child or a spouse).					
	I have had a large unexpected increase in expenses within the last six months.					

tachments	
You must attach proof of your extreme financial hardship. Include copies (please do not ser receipts, or letters from your landlord, mortgage, or utility company. List the attachments bel	
Toologics, or receive from your randoral, more tauge, or arming company. Electric areas mineric being	
	∑ No Ni
	nse o
	for —
nments	
If you need more space, please attach a separate sheet.	
ote: If your premium is more than 60 days past due and you do not subervice by the return date on page 1, your MassHealth coverage will end	
certify that I have read or had read to me the information on this application and that I unders nder the penalty of perjury that the information on this application and any supplements to it	
you are acting on behalf of someone in filling out this application, a MassHealth Eligibility Repent back with this application. Your signature on this application as an eligibility representative and complete to the best of your knowledge.	
X	
Signature of applicant or eligibility representative	Date
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