Report Insurance Coverage Changes to Mississippi Medicaid

hŦŦλÖŜ of Recovery

Recipient's name: _____ Medicaid # _____

Other Medicaid recipients in this household with this insurance:

Recipient's name: _____ Medicaid # _____DOB_____
Recipient's name: _____ Medicaid # _____DOB_____
Recipient's name: _____ Medicaid # _____DOB_____
Recipient's name: _____ Medicaid # _____DOB_____
Recipient's name: _____ Medicaid # _____DOB_____

Type of information to report:

☐ Add insurance coverage information

☐ Change in insurance information on Medicaid's file

☐ Remove insurance coverage information on Medicaid's file

Please complete the following information:

Name of Insurance Company: _____

Address: _____

Name of Insured (Subscriber or Policyholder):_____
Policy Number: _____Group #_____
Group Name: _____
Effective Date: _____
Termination Date:_____
What does this policy cover? (Check all that apply)
Major Medical ☐ Hospital ☐ Cancer ☐ Drugs ☐ Dental ☐ Vision ☐ Accident ☐ Medicare Suppl A and/or B ☐

Changes in coverage: _____

_____

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