Report Insurance Coverage Changes to Mississippi Medicaid

Bureau 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: _____

_____

This form may be faxed or mailed:

Fax to: (601) 359-6294
Mail to: Bureau of Recovery
Walter Sillers Building
Suite 1000
550 High Street
Jackson, MS 39201

Click here to send by email