

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 _____

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