Optional Form

MISSISSIPPI COORDINATED CARE OPTIONAL ENROLLMENT FORM

MISSISSIPPI DIVISION OF MEDICAID

Please complete all sections and return this form back to the Division of Medicaid (DOM) in the envelope included.

Section 1 Personal Information

MEDICAID NUMBER or SOCIAL SECURITY NUMBER _____

You must have Medicaid to participate in this program.

_____ LAST NAME (Print)

_____ FIRST NAME (Print)

_____ Middle Initial

_____ Address Where You Live

_____ City

_____ State

_____ Zip Code

_____ County

_____ Mailing Address (If Different)

_____ City

_____ State

_____ Zip Code

(_____)_____ Phone Number (If Available)

_____/_____/_____ Your Birthday (mm/dd/yyyy)

_____ Age

Are You Pregnant (Check one)

☐ Yes
☐ No

What language is spoken in the home?

English ☐ Spanish ☐ Other:_____

Section 2 Coordinated Care Organization (Please choose one)

Put a check mark by the Coordinated Care Organization (CCO) you want to take care of your health.

☐ Magnolia Health Care
☐ United Health Care
☐ Opt Out (Do not want to join)

My regular doctor is _____ (Doctor's Name)

Provider number is _____ (Medicaid, NPI or Identifier)

Section 3 Your Signature

I have read and understand the information on this application.

All information I gave on this form is true and correct. I know that if I get health care from a doctor not in my CCO that I will have to pay.

_____ Your signature/or witness

_____ DATE

Information that you give is private. Your medical information can only be shared if needed to give medical services. If you get services under the CCO, you give the CCO right to give Medicaid information about your health.