

MississippiCAN

Optional Change Form



MISSISSIPPI DIVISION OF
MEDICAID

MississippiCAN Enrollment

P.O. Box 23078
Jackson, MS 39225
Phone: 1-800-884-3222
Fax: 1-888-495-8169

<https://medicaid.ms.gov/program/managed-care/>

Please choose your preferred plan.

- Magnolia Health Molina Healthcare
 UnitedHealthcare Opt out (Regular Medicaid)

Section 1 Personal Information **Indicates required field*

*Beneficiary Name:	
*Date of Birth: (mm/dd/yyyy)	
*Medicaid ID # or *Social Security #	
*Mailing Address:	
*City/State:	
County:	
Home or Cell Phone:	

Section 2 Primary Care Physician Information **Indicates required field*

*Do you have a primary care physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO
*If yes, primary care physician name?	First _____ Last _____
City:	
County:	
Facility Name:	
Physician Telephone Number:	

Comments:

Section 3 Your Signature **Indicates required field*

*Signature:	Date:

****For Office use only
Dating of Processing:**

**Received by:
Revised 04/26/2018**