

MISSISSIPPI COORDINATED CARE OPTIONAL ENROLLMENT FORM



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

***Indicates required field**

Section 1 Personal Information

*BENEFICIARY MEDICAID NUMBER OR *SOCIAL SECURITY NUMBER		<input type="text"/>			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		City	State	Zip Code		
()	/	/				
Phone Number (If Available)		*Your Birthday (mm/dd/yyyy)		Age	Are You Pregnant (Check one)	
What language is spoken in the home?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
English <input type="checkbox"/>	Spanish <input type="checkbox"/>	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.

<input type="checkbox"/> Magnolia Health	*Do you have a regular primary care physician?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Molina Healthcare	*If yes, primary care physician name	First _____	Last _____
<input type="checkbox"/> United Healthcare	City:	_____ County: _____	
<input type="checkbox"/> Opt out (Regular Medicaid)	Facility Name:	_____ Telephone Number: () _____ - _____	

Section 3 Your Signature

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.

I have read and understand the information on this application.

_____ *Your signature /or witness	_____ DATE
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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.