CHIP

Change Form

Please choose your preferred plan.

☐ United Healthcare ☐ Molina Healthcare

Indicates required field

MISSISSIPPI DIVISION OF MEDICAID

SECTION 1: PERSONAL INFORMATION	
***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	
***Do you have a primary care physician?**	☐ YES ☐ NO
***If yes, primary care physician name?**	First_____Last_____
City:	
County:	
Facility Name:	
Physician Telephone Number:	

PLEASE MAIL ALL ENROLLMENT FORMS TO:

MississippiCHIP Enrollment
P.O. Box 23078
Jackson, MS 39225
OR
Fax: 1-866-644-6050

HOW TO CHECK THE STATUS OF ENROLLMENT FORM:

If you would like to check eligibility or check the status of your enrollment form, please call 1-800-884-3222.

Please allow 5 business days for enrollment forms to be processed.

https://medicaid.ms.gov/programs/managed-care/

COMMENTS:

SECTION 3: YOUR SIGNATURE *(Signature of Applicant or Head of Household/ Authorized Representative)*	
***Legible Signature:**	***Date:**

Received by: