MississippiCAN

Optional Change Form

☐ Magnolia Health ☐ Molina Healthcare
☐ Opt Out (Medicaid)

Please choose your preferred health plan.

MISSISSIPPI DIVISION OF MEDICAID

*Indicates required field

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:

MississippiCAN 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:***