Report Insurance Coverage Changes to Mississippi Medicaid

Office of Recovery

Recipient's name: _____Medicaid # _____

Other Medicaid recipients in this household with this insurance:

Recipient's name:_____Medicaid #_____DOB_____
Recipient's name:_____Medicaid #_____DOB_____
Recipient's name:_____Medicaid #_____DOB_____
Recipient's name:_____Medicaid #_____DOB_____
Recipient's name: _____Medicaid # _____DOB_____

Type of information to report:

_____Add insurance coverage information

_____Change in insurance information on Medicaid's file

_____Remove insurance coverage information on Medicaid's file

Please complete the following information:

Name of Insurance Company: _____

Address: _____

Name of Insured (Subscriber or Policyholder):_____
Policy Number: _____**Group #**_____
Group Name: _____
Effective Date: _____
Termination Date:_____
What does this policy cover? (Check all that apply)
Major Medical ___Hospital ____Cancer ____Drugs ____Dental ____Vision ____Accident___Medicare Suppl A and/or B_____

Changes in coverage: _____

_____

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