

CHIP

Change Form

Please choose your preferred plan.

- ☐ Molina Healthcare ☐ Magnolia Health
☐ TrueCare



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:**

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:
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(Signature of Applicant or Head of Household/ Authorized Representative)

Received by:
Revised 02/03/2025