

Report Insurance Coverage Changes to Mississippi Medicaid

Bureau 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: \_\_\_\_\_

\_\_\_\_\_

This form may be faxed or mailed:

Fax to: (601) 359-6294  
Mail to: Bureau of Recovery  
Walter Sillers Building  
Suite 1000  
550 High Street  
Jackson, MS 39201