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MEDICAID ELIGIBILITY  
FORMS AND INSTRUCTIONS

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DOM-331 - REQUEST FOR INFORMATION CONCERNING INSURANCE

**PURPOSE AND USE**

This form is used to obtain information concerning any insurance policies a client may have. This does not pertain to Medicare insurance. This form also is a release from the client authorizing the Division of Medicaid to obtain this information for the purpose of determining the client's Medicaid eligibility.

**INSTRUCTIONS**

Prepare the original and 1 copy and obtain the client or representative's signature. Once signed, retain the copy in the tickler file and mail the original to the appropriate insurance company. When the original is returned, discard the tickler copy and file the original in the case record.

Note in the Record of Contact the dates the forms were mailed and returned by the client and the appropriate insurance company.

Signature of Client or Representative: The client or representative will sign in this space.

The insurance company will complete the middle section of the form requesting insurance information.

The worker will sign, date and return address stamp the form.

REQUEST FOR INFORMATION CONCERNING INSURANCE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NO.: \_\_\_\_\_

Dear Sir:

I hereby authorize you to disclose any information concerning my insurance policy(ies) with your company to the Division of Medicaid for the purpose of determining my Medicaid eligibility.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF CLIENT OR REPRESENTATIVE

We have been advised that this person has a policy(ies) with your company. In order for us to determine his/her eligibility, please complete the following items. When completed, please return this form to the address shown below. Your cooperation with this request is greatly appreciated.

NAME OF INSURED \_\_\_\_\_

POLICY NUMBER(S) \_\_\_\_\_

OWNER OF POLICY(IES) \_\_\_\_\_

TYPE OF POLICY(IES) \_\_\_\_\_

FACE VALUE OF EACH POLICY \_\_\_\_\_

CASH SURRENDER VALUE (CURRENT) OF EACH \_\_\_\_\_

AMOUNT OF LOANS AGAINST EACH \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF INSURANCE OFFICIAL

\_\_\_\_\_  
DATE

Regional Office Address/Telephone \_\_\_\_\_

Medicaid Worker \_\_\_\_\_

Date \_\_\_\_\_