Click in area to type. Tab to move to different area.

NOTIFICATION OF OTHER INSURANCE COVERAGE

Name of Medicaid Beneficiary

Date or Birth

Medicaid ID

Policy Holder's Name

Insurance Carrier Name

Insurance Carrier Telephone Number

Policy Number

Group Number

Relationship to Policyholder

Provider Name

Provider Number

Provider Address

Provider Phone

Provider Contact Name

Date

FAX TO Division of Medicaid Third Party Liability: 1-601-359-6632