

**Department of Health and Hospitals  
 Medicaid Recipient Insurance Information Update  
 (Traditional MEDICARE Only)**

**Fax #: 225-342-1376**

**Phone #: 225-342-8662**

Date of Submission: \_\_\_\_\_

Provider Medicaid ID: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Submitter Name: \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

- Submission Status (check one):  General TPL update  
 Awaiting claim processing with updated TPL  
 Pharmacy awaiting TPL update to fulfill prescription

<b>Recipient Information:</b>	
Patient Name: _____	Parish of Residence: _____
Medicaid ID #: _____	Date of Birth (mm/dd/yyyy): ____/____/____
Hospital Account #: _____	Date of Service (mm/dd/yyyy): ____/____/____

Please update the patient's medical file by **ADDING** the following insurance:

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_

<b>Policy Holder Information:</b>	<b>Policy Information:</b>
Policy Holder SSN: ____ - ____ - ____	Policy #: _____
Policy Holder Name: _____	Group #: _____
Policy Holder DOB (mm/dd/yyyy): ____/____/____	Coverage Eff. Date (mm/dd/yyyy): ____/____/____
	Coverage End Date (mm/dd/yyyy): ____/____/____
	Carrier Code: _____

Please update the patient's medical file by **REMOVING** the following insurance:

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_

<b>Policy Holder Information:</b>	<b>Policy Information:</b>
Policy Holder SSN: ____ - ____ - ____	Policy #: _____
Policy Holder Name: _____	Group #: _____
Policy Holder DOB (mm/dd/yyyy): ____/____/____	Coverage Eff. Date (mm/dd/yyyy): ____/____/____
	Coverage End Date (mm/dd/yyyy): ____/____/____
	Carrier Code: _____

**PRIVACY AND CONFIDENTIALITY WARNING**

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