

Department of Health and Hospitals
Medicaid Recipient Insurance Information Update

Fax #: 1.877.204.1325 Phone #: 1.877.204.1324

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

Recipient Information:

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: _____

Policy Holder Information:

Policy Holder SSN: ____ - ____ - ____

Policy Holder Name: _____

Policy Holder DOB (mm/dd/yyyy): ____/____/____

Policy Information:

Policy #: _____

Group #: _____

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: _____

Policy Holder Information:

Policy Holder SSN: ____ - ____ - ____

Policy Holder Name: _____

Policy Holder DOB (mm/dd/yyyy): ____/____/____

Policy Information:

Policy #: _____

Group #: _____

Coverage Eff. Date (mm/dd/yyyy): ____/____/____

Coverage End Date (mm/dd/yyyy): ____/____/____

Carrier Code: _____

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