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:_____

Revised 7/1/09