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 Information:
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:	
Policy Holder Information:	Policy Information:
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

This Fax may contain Protected Health Information, Individually Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this Fax and any attachments thereto, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately and destroy the contents of this Fax and its attachments by deleting any and all electronic copies and any and all hard copies regardless of where they are maintained or stored.