Report Insurance Coverage Changes to Alabama Medicaid

List all Medicaid recipients in this household with this insurance:

Recipient's Name:_____Medicaid:_____DOB:_____

Recipient's Name:_____Medicaid:_____DOB:_____

Recipient's Name:_____Medicaid:_____DOB:_____

Recipient's Name:_____Medicaid:_____DOB:_____

Recipient's Name:_____Medicaid:_____DOB:_____

☐ **Add Insurance coverage information (Please include front and back copy of card)**

Name of Insurance Company:_____

Address:_____

Name of Policyholder:_____

Policy Number:_____Group# :_____

Effective Date:_____

☐ **Change in insurance information on Medicaid's file**

Termination Date:_____

Policy # change:

Old Policy #_____New Policy#_____

Name of Representative:_____Phone #_____

This form may be faxed or mailed:

Fax to: (334) 353-2922

Mail to: Insurance Update – Third Party
Alabama Medicaid Agency
P O Box 5624
Montgomery, Al 36103-5624