This form can be filled out while viewing in Adobe Acrobat Reader. Print it, then fax or mail to the address below.

Report Insurance Coverage Changes to Alabama Medicaid

Recipient's name: _____ Medicaid # _____

Other Medicaid recipients in this household with this insurance:

Recipient's name: _____ Medicaid # _____
Recipient's name: _____ Medicaid # _____
Recipient's name: _____ Medicaid # _____
Recipient's name: _____ Medicaid # _____
Recipient's name: _____ Medicaid # _____
Recipient's name: _____ Medicaid # _____

Type of information to report:

_____ Add insurance coverage information
_____ Change in insurance information on Medicaid's file

Please complete the following information:

Name of Insurance Company: _____

Address: _____

Name of Insured (Subscriber or Policyholder):

_____

Policy Number: _____ **Group #** _____

Group Name: _____

Effective Date: _____

Termination Date: _____

What does this policy cover? (Check all that apply)

Hospital ____ Physician ____ Drugs ____ Dental ____ Vision ____ Maternity ____

Changes in coverage: _____

This form may be faxed or mailed:

Fax to: (334) 353-2922
Mail to: Insurance Update – Third Party
Alabama Medicaid Agency
PO Box 5624
Montgomery, AL 36103-5624