**WISCONSIN DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-10115 (07/08)

**ME**

# MEDICAID HEALTH INSURANCE INFORMATION

1. Do not write in shaded areas (for office use only).
2. Policyholder is to complete this form. Answer ALL questions. Write "NONE" if a question does not apply to you.
3. Policyholder should list all persons in Section A who are applying for or are now receiving assistance, and are covered by other health insurance, whether or not the policyholder resides in the household.
4. Policyholders completing this form who are not living with eligible dependents must list in Section A all dependents who receive assistance.
5. Use a separate form for each carrier/policy. Ask for additional forms.
6. Once form is completed return to your local county/tribal social or human services agency.

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the Medicaid Program.

| **FOR OFFICE USE ONLY** | | |
|---|---|---|
| Casehead Name | | Case Number |
| TPL Transaction – Information Being<br>☐Added ☐ Changed or Ended ☐ Deleted | Agency Code | Worker Code |

**SECTION A – Recipient**

| Medicaid ID Number | Name (Last, First, MI) List all persons applying for Medicaid covered by the policy described in Section C. | Date of Birth (mm/dd/yy) | Relationship to policyholder (check one)<br>1 – Self, 2 – Spouse, 3 – Child, 4 – Stepchild, 5 - Other |
|---|---|---|---|
| | | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| | | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| | | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| | | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

**SECTION B – Policyholder Information**

| Type of policy<br>☐ Major Medicaid ☐ HMO / HMP / PPO ☐ Medicare Supplement ☐ Accident ☐ Other | | Is Policyholder an Absent Parent? (Parent who is continuously away from the home.) ☐ Yes ☐ No |
|---|---|---|
| Policyholder Name (Last, First, MI) | Social Security Number | Date of Birth (mm/dd/yy) |
| Policyholder Address (Street, City, State. Zip Code) | | |

**SECTION C – Insurance Information**

| Insurance Company Name | | | | |
|---|---|---|---|---|
| Insurance Company Address (Street, City, State, Zip Code) | | | | |
| Policy Number | Policy Start Date (mm/dd/yy) | Policy End Date (mm/dd/yy) | Group Name | Group Number |

**SECTION D - Employer Information** (Complete if Policyholder is Employed)

| Employer Name | Telephone Number |
|---|---|
| Employer Address (Street, City, State, Zip Code) | |
| Should Insurance Claims be sent to the Employer?<br>☐ Yes ☐ No ☐ Unknown | Medicaid Program Use Only – Insurance Company or Employer Billing Code |

I understand that as a condition of eligibility for Medicaid, I must report to the county/tribal social or human services agency any other person(s) that may be liable to pay for medical care for my family and me. I must also cooperate by giving information to assist the county/tribal social or human services agency in pursuing payment from any other person(s). I understand that any benefits for the cost of medical care which are available under a policy will be assigned to the State by law (s. 632.72, WI Statutes.) during any period of Medicaid eligibility. I understand that, within 10 days, I must report any changes in all of the above information. The information given above is true and complete to the best of my knowledge.

| **SIGNATURE** – Policyholder | Telephone Number | Date Signed |
|---|---|---|
| | | |