Department of Health and Hospitals
Medicaid Recipient Insurance Information Update
(Traditional MEDICARE Only)

Fax #: 225-342-1376 **Phone #: 225-342-8662**

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:_________________________________

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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:_________________________________

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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:_____________

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