The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Enrollment Center
333 Bridge Street
Springfield, MA 01103
1-888-665-9993
TTY: 1-888-665-9997
Fax: 413-785-4107

Financial Information Request

Name: _____ **Social security number:** _____

Address: _____ **City/Town/Zip:** _____

Name of financial institution: _____

Address: _____ **City/Town/Zip:** _____

You or your spouse have applied for MassHealth. You must get a copy of your bank accounts to us so we can complete the application process. If you do not have your account records, you can get them from your bank.

Sometimes banks charge a fee to get these records. You can get them at **no cost** with this form.

You need to complete one form for each bank where you have accounts.

- Complete the top of this form (**PLEASE PRINT** your name, address, and social security number and the name and address of the financial institution).
- In **Section 1**, list the account number and time period that you need the bank records for.
- In **Section 2**, tell the bank where you want the information sent (to you or to the MassHealth Enrollment Center listed above).
- Sign and date the form before you give it to your bank.
- Bring or mail the form to the bank.

Pursuant to M.G.L. c. 118E, § 23A, please provide, without charge, the deposit and withdrawal records for the accounts and time periods listed below for the above-named MassHealth (Medicaid) applicant, member, or spouse of an applicant or member.

Section 1

Account number: _____ Time period: _____

Account number: _____ Time period: _____

Account number: _____ Time period: _____

Section 2

Within two weeks of your receipt of this request, please send that information to:

◯ the above-named MassHealth applicant or member; or

◯ the MassHealth Enrollment Center listed above.

_____ _____
Signature of MassHealth Applicant/Member or Spouse Date

MassHealth Signature Amy Andrade