DCH-0078, REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

Michigan Department of Health and Human Services
(Revised 3-22)

SECTION 1 – REQUEST TO (Select one)

☐ Add ☐ Terminate ☐ Change

SECTION 2 – MEDICAID PROVIDER/MEDICAID HEALTH PLAN/LHD/MDHHS CASEWORKER INFORMATION *

Requester Name			Date
County/Local Health Department	Phone Number	Fax Number	Case Number (if available)

SECTION 3 – LIST OF BENEFICIARIES/CLIENTS TO ADD, TERMINATE OR CHANGE INSURANCE *

Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID

SECTION 4 – POLICYHOLDER INFORMATION *

Policyholder Name (Last, First, Middle)		Date of Birth
Employer Name	Social Security Number	Employer City and State

Type of Coverage (Select one)

☐ Traditional ☐ Managed Care (Preferred Provider Organization, Health Maintenance Organization, Point of Service)

Health Insurance Company Name	Group/Policy Number	Certificate/Contract Number
Pharmacy Insurance Name	Dental Insurance Name	Vision Insurance Name

SECTION 5 – REASON FOR CHANGE

☐ Divorce Date of Divorce

☐ Coverage Termination | Date of Termination

☐ Military Discharge | Date of Discharge

☐ Employment Termination | Date of Termination

☐ Other (explain) Date of Change Reason

Attachments: Attach documentation to substantiate a request to terminate or change insurance coverage, such as a letter from an insurance company or employer.

Comments

Submit

MDHHS-Third Party Liability Division
Fax: 517-346-9817

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title V and Title XIX of the Social Security Act **COMPLETION:** Is voluntary.

COMPLETE INSTRUCTIONS FOR DCH-0078, REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

DCH-0078 is a formal request for change in other insurance status and must be submitted by the Medicaid provider, Medicaid Health Plan, Local Health Department or the Michigan Department of Health and Human Services caseworker to add, terminate, or change beneficiary insurance information other than Medicaid.

INSTRUCTIONS:

To add, terminate or change other insurance on-line, visit https://www.Michigan.gov/ReportTPL to access the form and instructions.

To submit the form via fax or mail:

- PRINT or TYPE to complete the form
- Place a check mark in the appropriate "Add," "Terminate," or "Change" field
- Sections denoted by * are mandatory to be completed
- Attach clear copy of insurance card (front and back) when adding insurance (if available)
- Retain a COPY in beneficiary file
- Submit form and applicable attachments
  via: Fax Number: 517-346-9817

Mail to:

Michigan Department of Health and Human Services
Third Party Liability Division
Bureau of Medicaid Policy, Operations & Actuarial Services
PO Box 30479
Lansing MI 48909

Allow 7-10 business days for the request to be completed. To verify the request has been completed, view the beneficiary eligibility information in the Community Health Automated Medicaid Processing System (CHAMPS).

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