Michigan Department of Community Health

# REQUEST TO ADD COMMERCIAL INSURANCE INFORMATION FOR HEALTH PLAN MEMBERS

## INSTRUCTIONS:

- Complete this form and send to:
  **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**
  **THIRD PARTY LIABILITY DIVISION**
  **BUREAU OF FINANCIAL MANAGEMENT**
  **PO BOX 30479**
  **LANSING MI 48909**

  **FAX:** (517) 346-9817

  **EMAIL:** TPL_Health@Michigan.Gov

- This form and other information are also available through the internet at:
  **www.michigan.gov/mdch/1,1607,7-132-2945_5100-20412--,00.html**
  (Access this link by visiting www.michigan.gov/mdch , click on Providers, Information For Medicaid Policy, Third Party Liability)

| | | |
|---|---|---|
| Health Plan Name | | Date |
| Contact Person Name | | Contact Person's Phone Number |
| Medicaid Beneficiary Name | | Medicaid I.D. Number |
| Commercial Insurance Name | | Commercial Insurance Phone Number |
| Commercial Insurance COMPLETE ADDRESS (No. & Street, Suite No., City, State, ZIP Code) | | |
| Type of Coverage: (use an "X")<br>☐ **Traditional**<br>☐ **Managed Care** (Preferred Provider Organization, Health Maintenance Organization, Point of Service) | | |
| Name of Pharmacy Benefit Manager (if utilized) | Brand Name Drug CoPay | Phone Number (if available) |
| Policyholder Name | | Policyholder Date of Birth |
| Policyholder Social Security Number / Contract Number | | |
| Group Number | | Effective Date of Commercial Coverage |
| Employer Name (if known) | | |
| Additional Comments *(include covered dependents and their Medicaid ID Number)*: | | |
| Has this information been verified with the Commercial Carrier?<br>☐ **YES** ☐ **NO** | | |

| | |
|---|---|
| **AUTHORITY:** | Title XIX of the Social Security Act |
| **COMPLETION:** | Is VOLUNTARY, but is required if Medical Assistance program payment is desired. |

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