



Insurance Coverage Request Form

This form is utilized to add, terminate or change multiple insurance policy information for a beneficiary. Please add all beneficiary information as well as all policy holder information. Multiple beneficiaries can be added to this request, as long as the changes are identical for the beneficiaries included on this form. Please complete as much information as possible to ensure timely completion. All required information is needed in order for this form to be submitted. Submitted forms that are missing information may not be reviewed. You will receive a confirmation message indicating that your information has been received. Please allow up to 10 business days for information to be verified and updated in the system.

For additional assistance, please contact Provider Support at 1-800-292-2550.

Requestor Information

First Name*	<input type="text" value="Requestor First Name"/>
Last Name*	<input type="text" value="Requestor Last Name"/>
Organization Type*	<input type="text" value="Select a Organization Type"/> <ul style="list-style-type: none"> Select a Organization Type Children's Special Health Care Services Claims Department of Human Services Local Health Department Member Providers
Organization Name	<input type="text"/>
Phone Number*	<input type="text"/>
Email Address	<input type="text" value="Requestor Email Address"/>



Member Information

First Name*	<input type="text" value="Beneficiary/Client First Name"/>
Last Name*	<input type="text" value="Beneficiary/Client Last Name"/>
Date of Birth*	<input type="text" value="Beneficiary/Client Date of Birth, Format: MM-DD-YYYY"/>
MiHealth ID*	<input type="text" value="Beneficiary/Client MiHealth ID Number, Format: Up to a 10 digit number"/>
Case Number	<input type="text" value="Beneficiary/Client Case Number"/>
	<input type="button" value="Add Additional Member"/>



Additional Members can be submitted.

New Drop down options

Policy Information

Request Type*	<input type="text" value="Select a Request Type"/> <ul style="list-style-type: none"> Select a Request Type Add Change Terminate
Coverage Type*	<input type="text"/>

Policy #1

Company Name*	<input type="text" value="Company Name"/>
Policy Number	<input type="text" value="Policy Number/Contract Number"/>
Group Number	<input type="text" value="Group Number"/>



Member Information

First Name*	<input type="text" value="Beneficiary/Client First Name"/>
Last Name*	<input type="text" value="Beneficiary/Client Last Name"/>
Date of Birth*	<input type="text" value="Beneficiary/Client Date of Birth, Format: MM-DD-YYYY"/>
MiHealth ID*	<input type="text" value="Beneficiary/Client MiHealth ID Number, Format: Up to a 10 digit number"/>
Case Number	<input type="text" value="Beneficiary/Client Case Number"/>
<input type="button" value="Add Additional Member"/>	



Policy Information

Request Type*	<input type="text" value="Select a Request Type"/>
Coverage Type*	<input type="text" value="Select a Coverage Type"/>
Policy #1	<input type="text" value="Select a Coverage Type"/>
Company Name*	<input type="text" value="Dental"/>
Policy Number	<input type="text" value="Long-Term Care"/>
Group Number	<input type="text" value="Medical"/>

Medicare
Pharmacy
Psychiatric
Vision
Policy Number/Contract Number

New drop down for Coverage Type



Policy #1

Company Name*	<input type="text" value="Company Name"/>
Policy Number	<input type="text" value="Policy Number/Contract Number"/>
Group Number	<input type="text" value="Group Number"/>
First Name	<input type="text" value="Policy Holder First Name"/>
Last Name	<input type="text" value="Policy Holder Last Name"/>
Date of Birth	<input type="text" value="Policy Holder Date of Birth, Format: MM-DD-YYYY"/>
Social Security Number	<input type="text" value="Policy Holder Social Security Number, Format: 9 digit number"/>
Employer Name	<input type="text" value="Policy Holder Employer Name"/>
<input type="button" value="Add Additional Policy"/>	

Click for additional assistance

Add more than 1 Policy

Additional Information

Comments	<input type="text"/>
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Last Name 

Date of Birth 

Social Security Number

Employer Name

Additional Information

Comments

- This request is in response to a Claim Void Letter
- Remember Requestor Information 

By checking this box, the individual submitting the request won't have to complete their information again.



Thank you

Thank you Jan for this submission. Please allow up to 10 business days for MDCH to update our records.

Once the form is submitted, the individual will receive this notice.