

Completion Instructions for DCH-0078 Request to Add, Terminate or Change Other Insurance

Form 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
Operations 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).

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

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

Michigan Department of Health and Human Services

REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

ADD

TERMINATE

CHANGE

SECTION 1 – Medicaid Provider/Medicaid Health Plan/LHD/MDHHS Caseworker Information *

Requestor Name	Date	County/Local Health Department
Phone Number ()	FAX Number ()	Case Number (if available)

SECTION 2 – 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 3 – Policyholder Information *

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name
Social Security Number	Employer City and State	
Type of Coverage (use an "X") <input type="checkbox"/> Traditional <input type="checkbox"/> 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 4 – Reason For Change

<input type="checkbox"/> Divorce →	Date of Divorce	<input type="checkbox"/> Military Discharge →	Date of Discharge
<input type="checkbox"/> Coverage Termination →	Date of Termination	<input type="checkbox"/> Employment Termination →	Date of Termination
<input type="checkbox"/> 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:

MDCH - THIRD PARTY LIABILITY DIVISION

FAX (517) 346-9817

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