CHANGE OF STATUS – PREMIUM ASSISTANCE ADJUSTMENT

Michigan Department of Health and Human Services
Michigan Drug Assistance Program (MIDAP)

REASON FOR CHANGE OF STATUS: Check all that apply and fill out the corresponding fields below.

☐ Legal Name Change	☐ Change in Prescription/Medical Coverage
☐ Address Change	☐ Premium Assistance Adjustment
☐ Household Size Change	☐ Income Change

DEMOGRAPHIC INFORMATION: Please print. All applicant information will be sent to the address entered below.

MIDAP ID (found on your SGRX/MIDAP card, if applicable)		
Legal Last Name	Legal First Name	Maiden Name
Date of Birth	Social Security Number	

ADDRESS CHANGE: If your address or phone number changed, complete the following.

Address			Apartment Number
City	State **MI**	Zip Code	County
Phone Number	May we leave a voicemail? ☐ Yes ☐ No		

HOUSEHOLD SIZE

Previous Household Size	Current Household Size

INCOME CHANGE

Do you have income?

☐ Yes (submit most recent paystub)

☐ No If you have no income or are low income, you must apply to Medicaid and provide the tracking number to MIDAP before any coverage can be provided.

Date of MDHHS Application / / MDHHS Tracking Number:

PRESCRIPTION/MEDICAL INSURANCE COVERAGE

If your prescription/medical insurance coverage has changed, indicate the change below and attach a copy of your insurance card (front and back).

☐ No Insurance	☐ Medicare Part C (Advantage)
☐ Private – Employer (Employer-Sponsored Insurance	☐ Medicare Part D (Prescription)
☐ Private – Individual (paid for by you or another party	☐ COBRA
☐ Indian Health Services (IHS)	☐ Qualified Heath Plan (Marketplace)
☐ Veteran's Administration, Tricare or other military healthcare	☐ Other Plan _____

PREMIUM ASSISTANCE ADJUSTMENT

Do you have Premium Assistance and have a change to report? ☐ Yes ☐ No
If Yes, fill out the following and **submit the most current invoice** (the premium amount, policy number and address of the insurance company must be present on the invoice). ☐ My current insurance plan is no longer active effective __/__/____. Stop making premium payments on my account.
☐ My premium rate has changed effective __/__/____. Pay the new premium amount of **$**_____. ☐ My insurance account is past due. The amount due is **$**_____ for the month(s) of __/__/____ through __/__/____. ☐ My insurance account has a credit in the amount of **$**_____ as of __/__/____.

CHANGE OF STATUS SIGNATURE

Signature of Applicant	Date	Client Phone Number

Mail or fax completed form and all supporting documentation to:

MDHHS-MIDAP
109 West Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Fax: 517-335-7723
Phone: 888-826-6565

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