BHSF Form DRA-1 Rev. 2/07 Prior Issue Obsolete

Louisiana Medicaid – U.S. Citizen Information Form

- 1. Please read the flyer "Important News from Louisiana Medicaid" that came with this form.
- 2. Fill out and sign this form. If more space is needed, use another sheet of paper.
- **3. Get this form to us right away. Mail, fax, or take this form** to your local Medicaid office. If you need the address or fax number, call 1-888-342-6207. If you are deaf or hard of hearing, call 1-800-220-5404.

If you choose to mail original proof of citizenship and/or identity, you do so at your own risk. Originals will be mailed back to you. We also accept photocopies.

Please give us the following information about each person who gets or is applying for Medicaid.

Social Security Number:	last)Mother's Name:		
Mother's Maiden Name:Place of Birth: City			Country
Do they now have or did they ever get			
If yes , which one? \square Medicare \square SS		., (225)	
Person #2: Name: (first, middle initial,	last)		
Social Security Number:	Mother's Name:		
Mother's Maiden Name:			
Place of Birth: City			Country
Do they now have or did they ever get	Medicare or Supplemental Securi	ty Income (SSI)?	Yes □ No
If yes , which one? \square Medicare \square SS			
Person #3: Name: (first, middle initial,	last)		
Social Security Number:	Mother's Name:		
Mother's Maiden Name:			
Place of Birth: City	Parish/County	State	Country
Do they now have or did they ever get	Medicare or Supplemental Securi	ty Income (SSI)?	Yes □ No
If yes , which one? \square Medicare \square SS	SI		
Person #4: Name: (first, middle initial,	last)		
Social Security Number:	Mother's Name:		
Mother's Maiden Name:			
Place of Birth: City	Parish/County	State	Country_
Do they now have or did they ever get	Medicare or Supplemental Securi	ty Income (SSI)?	Yes □ No
If yes , which one? \square Medicare \square SS	SI		
Sign your name here		Date	
_		Data	