

**Division of Medical Assistance
Health Insurance Information Referral Form**

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No. _____

(2) _____ Policy/Cert No. _____

Reason For Referral

1. _____ Recipient never covered by or added to above policy(s) (**EOB attached**)

2. _____ Recipient's insurance coverage terminated (**EOB attached**)

3. _____ New policy not indicated on Medicaid ID card (**EOB or copy of insurance card attached**) Indicate type coverage:

(Do not include Medicare)

_____ Major Medical

_____ Hosp/Surgical

_____ Basic Hospital

_____ Dental

_____ Cancer

_____ Accident

_____ Indemnity

_____ Nursing Home

Attach original claim, a copy of the EOB **or** a copy of the insurance card and submit to: DMA - TPR, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will update the system and forward claims to EDS within 10 working days after receipt.

Provider Name: _____ Provider Number: _____

Submitted By: _____ Date Submitted: _____

Telephone Number: _____