

Ohio Department of Medicaid
HEALTH INSURANCE FACT REQUEST

Complete this form to request an update of the recipient's private health insurance or Medicare information in the Medicaid claims payment system. Providers are expected to verify the recipient's health care coverage.

Please select which health insurance information to update:	<input type="checkbox"/> Private health insurance <input type="checkbox"/> Medicare
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Provider Information:

Provider #	Provider Name	
Address		
City	State	Zip Code
Contact Person	Phone Number	

Recipient Information:

Patient(s) Name	Medicaid Billing #	Patient's Phone Number	
Name of Insurance			
Address			
City	State	Zip Code	Insurance Carrier Phone Number
Policy Holder Name	Policy # or Medicare #	Policy Group Number	
Policy Holder Social Security Number (SSN)		Policy Holder Phone Number	
Policy Holder's Employer Name	Employer Address	Employer City	
Employer State	Employer Zip Code	Employer Phone Number	
If payment has been received from health insurance other than Medicaid or Medicare, please note 1 st payment date: ____ / ____ / ____			
Date health insurance terminated per attached documents: ____ / ____ / ____			
Additional Comments			

Return original to: Coordination of Benefits Section
 Cost Avoidance Unit
 P.O. Box 182410
 Columbus, Ohio 43218-2410

If you have questions contact the Coordination of Benefits Section at (614) 752-5768. The FAX number is (614) 728-0757.