Medicaid Insurance Verification Services
For
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE INFORMATION REFERRAL FORM

This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.

Beneficiary Name: _____ Date Referral Completed _____

Medicaid ID#: _____ SSN: _____

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Employer's Name: _____

Employer's Address: _____

REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)

_____ 1. The beneficiary's Medicaid eligibility file does not list the policy above.

_____ 2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:

_____ a. beneficiary has never been covered by the policy

_____ b. beneficiary's coverage ended (date) _____

_____ c. policy lapsed (date) _____

_____ d. carrier has changed; new carrier is _____

_____ e. other _____

PLEASE ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Please fax this information to Medicaid Insurance Verification Services at (803) 252-0870 **or** the completed form may be mailed to the following address:

Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29201

Provider or Department Name: _____ Provider ID# _____

Contact Person: _____ Phone #: _____

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