Report Insurance Coverage Changes to Alabama Medicaid

List all Medicaid Recipients in this household with this insurance:

Recipient's Name:	Medicaid Number:	Date of Birth:

Add Insurance Coverage Information
(Please include a copy of the front & back of the insurance card)

Name of Insurance Company:	
Address of Insurance Company:	
Name of Policyholder:	
Policy Number:	
Group Number:	
Effective Date:	

Change Insurance Information Previously Provided to Medicaid

Termination Date of Policy:	

Policy Number Change:	Old Policy Number:	
	New Policy Number:	

Information Regarding Individual Completing Form

Name of Individual Completing Form:	
Telephone Number:	

Please Return the Completed Form

Email:	UpdateHealthInsurance@Medicaid.Alabama.Gov
Fax:	(334) 353-2922
Mail:	Alabama Medicaid Agency ATTN: Third Party Division – Insurance Update PO Box 5624 Montgomery, AL 36103-5624