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: _____

DMA 2057
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