Clear Form

Minnesota Department of **Human Services**

DHS-6340-ENG 10-14

Minnesota Health Care Programs (MHCP)

Other Health Insurance Reporting Form

Managed Care Organizations: Use this form to notify MHCP when you discover that an MCO-enrolled MHCP recipient is covered by other health insurance. Fax the form to the Benefit Recovery Section at 651-431-7431.

Recipient/Other Insurance Information

RECIPIENT LAST NAME	FIRST NAME	MI	MHCP PMI NUMBER	
CASE NUMBER	DATE OF BIRTH __ __/__ __/__ __ __ __	POLICY NUMBER	POLICY BEGIN DATE __ __/__ __/__ __ __ __	POLICY END DATE __ __/__ __/__ __ __ __
OTHER INSURANCE COMPANY NAME	POLICY HOLDER LAST NAME	FIRST NAME	MI	
OTHER INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE	

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CASE NUMBER	DATE OF BIRTH __ __/__ __/__ __ __ __	POLICY NUMBER	POLICY BEGIN DATE __ __/__ __/__ __ __ __	POLICY END DATE __ __/__ __/__ __ __ __
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OTHER INSURANCE COMPANY NAME	POLICY HOLDER LAST NAME	FIRST NAME	MI	
OTHER INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE	

MCO Contact Information

NAME OF PERSON SUBMITTING INFORMATION (Last, First)	PHONE NUMBER	NAME OF MCO	DATE SUBMITTED __ __/__ __/__ __ __ __

DHS USE ONLY

NAME OF PERSON RECEIVING INFORMATION (Last, First)	DATE RECEIVED __ __/__ __/__ __ __ __