

MEDICAID PROGRAM Request for Life Insurance Policy Information

Name of Insurance Co.	Name of Insured	
Address	Address	
City, State, Zip Code	City, State, Zip Code	
	Case I.D. #	SS #

In order to determine Medicaid eligibility for the person named above, the following information on his or her life insurance with your company is needed. The information shown has been provided by our client. Please provide the missing data; revise the information shown, **if** incorrect; and submit your reply to our address below. Our applicant/recipient's signed consent for disclosure of this information follows. We appreciate your assistance.

Agency Representative	Parish Bureau of Health Services Financing
Address	City, State, Zip Code

Applicant/Recipient and Spouse Authorization

I understand that any information obtained will be kept confidential and that: 1) this authorization is valid for only three months from the date of my signature; 2) I have the right to revoke this authorization at any time before the information is released; 3) the specific information requested is outlined below; 4) I have the right to obtain a copy of the record of information released; and 5) this authorization is not required as a condition of doing business with the _____ (Name of Insurance Company). You are hereby authorized to provide Louisiana's **Medicaid Program** with the information requested below.

Applicant's/Recipient's Signature	Spouse's Signature
Date	Date
Witness	Witness

Insurance Company Response

Name of Agent				District			
Policy #	Issue Date	Plan of Insurance	Face Value	CSV Minus Encumbrances	Dividends	Owner	Is policy Irrevocable?
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
Signature & Phone # of Insurance Co. Representative						Date	