

**DEPARTMENT OF HEALTH AND HOSPITALS**  
**Medicaid Program**  
Application Verification Request Form

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

The items listed on this form are requested to help us decide if you are eligible for Medicaid. Please send copies of the items checked (☑) to: **Medicaid Office, P. O. Box 91278, Baton Rouge, LA 70821-9893** by \_\_\_\_\_. **If you need more time or help to get any of the items listed, call the Medicaid office at (877-252-2447) by this date.**

- Copy of Tax Return, with Schedule C attached, from self-employment for: \_\_\_\_\_.
- Any medical insurance cards or other proof of medical insurance coverage {include proof of the costs or premium amount(s) and a copy of both sides of the card(s)}.
- Last month's statements from all bank accounts and proof of any interest earned.
- All life and burial insurance policies (current or lapsed) and funeral contracts.
- Proof of the value of savings bonds, stocks, owned mortgages or notes, trust funds or other financial Instruments.
- Proof of ownership, value, and amount owed on any vehicles (car, boat, truck, etc.).
- Proof of ownership, value, and amount owed on any land (including land in which you have joint ownership or ownership in an undivided estate).
- Medical bills and receipts for hospital, doctor visits, prescribed medicines, lab tests, X-rays, and any other medical services.
- Social Security numbers for \_\_\_\_\_.
- Other: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency Representative

( ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date