LOUISIANA DEPARTMENT OF HEALTH

CONTACT INFORMATION FORM

MEMBER INFORMATION:		
Name:		
Medicaid ID:	Social Security Number:	Date of Birth:

*Please include all known information. The **member's name**, **date of birth** and at least the **last four numbers of the Social Security Number** are required to process the form.*

CHANGE OF CONTACT INFORMATION:			
HOME ADDRESS:	Street Address:		Apt/Suite Number:
	City:	State:	ZIP Code:
MAILING ADDRESS: *(if different from Home Address)*	Street Address:		Apt/Suite Number:
	City:	State:	ZIP Code:
Cell Phone Number:		Email Address:	
Home/Alternative Phone Number:		Do you want to receive information from Medicaid by email? ☐ Yes ☐ No	

SIGN THIS FORM:

By signing this form, I am giving my permission to the State of Louisiana and its agents to verify the information given on this form. Under penalty of perjury, I certify that all information contained in this form is true and correct to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____

Must be signed by hand. Digital or electronic signature will not be accepted.

FORMS MAY BE SUBMITTED:

By email to **MyMedicaid@la.gov**

By fax to **1-877-523-2987**