Medicaid/LaCHIP Office
P. O. Box 91283
Baton Rouge, LA 70821

LOUISIANA DEPARTMENT OF HEALTH

Address Change Report Form

Enter all available information (if information is unknown leave blank).

Member Information

Name:_____ SSN:_____ Date of Birth: _____

Medicaid ID:_____ DOC #: _____

Where do you want to receive your Medicaid mail?

Change of Address Information			
Is your home address the same as your mailing address? ☐ Yes ☐ No			
Mailing Address	Street Address or PO Box		
	City	State	Zip Code
Home Address Complete this section only if your home address is different than your mailing	Street Address (Must be a physical address)		
	City	State	Zip Code
Phone Number	( ) -		

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: _____

Submit this form

Send the completed form to Louisiana Medicaid via email, fax, or postal mail.

Email: IMDOC@la.gov

Fax Number 1-877-523-2987

Mailing address: P. O. Box 91283, Baton Rouge, LA 70821