STATE OF ALASKA
DIVISION OF PUBLIC ASSISTANCE

PREGNANT WOMEN MEDICAID PROGRAM CHANGE REPORT FORM

IF YOU RECEIVE PRGNANT WOMEN MEDICAID PROGRAM BENEFITS, YOU MUST REPORT TO THE PUBLIC ASSISTANCE OFFICE:

1. Address changes (both residence and mailing); and
2. The date your pregnancy ends.

THESE CHANGES MUST BE REPORTED WITHIN 10 DAYS AFTER THE CHANGE OCCURS. YOU MUST ALSO TELL US IF YOUR MEDICAL INSURANCE CHANGES.

INSTRUCTIONS

Fill in your name, case number, and today's date. Check the appropriate box(es), complete the information requested, and bring or mail this form to your public assistance office.

NAME:_____ CASE NUMBER:_____

TODAY'S DATE:_____

☐ MEDICAL INSURANCE STARTED:_____ ENDED:_____

NAME OF COMPANY:_____

☐ MY ADDRESS HAS CHANGED. MY NEW ADDRESS IS:

RESIDENCE:_____ MAILING: _____

_____ _____

_____ _____

☐ MY PREGNANCY HAS ENDED. MY BABY WAS BORN ON:_____
(Date)

AT:_____
(Hospital Name)

SIGNATURE:_____ DATE:_____

PHONE NUMBER:_____

GEN 32A 06-3712 (12/88)

STATE OF ALASKA
DIVISION OF PUBLIC ASSISTANCE

HEALTHY CHILDREN MEDICAID PROGRAM
CHANGE REPORT FORM

IF YOUR CHILDREN RECEIVE HEALTHY CHILDREN MEDICAID PROGRAM BENEFITS, YOU ARE REQUIRED TO REPORT TO THE PUBLIC ASSISTANCE OFFICE:

1. Address changes (both residence and mailing);
2. When people enter or leave your household;
3. Income changes; and
4. Medical coverage changes.

THESE CHANGES MUST BE REPORTED WITHIN 10 DAYS AFTER THE CHANGE OCCURS.

INSTRUCTIONS

Fill in your name, case number, and today's date. Check the appropriate box(es), complete the information requested, and bring or mail this form to your public assistance office.

NAME:_____ CASE NUMBER:_____

☐ MY ADDRESS HAS CHANGED. MY NEW ADDRESS IS:

RESIDENCE:_____ MAILING: _____

_____ _____

_____ _____

☐ SOMEONE ENTERED/LEFT MY HOUSEHOLD:

NAME:_____ RELATIONSHIP:_____

DATE ENTERED/LEFT (Circle One):_____

☐ MY HOUSEHOLD INCOME HAS CHANGED:

NAME AND PHONE NUMBER OF EMPLOYER:_____

TYPE OF INCOME:_____ NEW GROSS AMOUNT: $_____

DATE RECEIVED:_____ RECEIVED BY:_____

☐ MY HOUSEHOLD'S MEDICAL COVERAGE HAS CHANGED AS FOLLOWS:_____

_____

_____

SIGNATURE:_____ DATE:_____

PHONE NUMBER:_____