WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10115 (01/11)

ME

BADGERCARE PLUS / MEDICAID HEALTH INSURANCE INFORMATION

1. Do not write in shaded areas (for office use only).
2. Policyholder is to complete this form. Answer ALL questions. Write "NONE" if a question does not apply to you.
3. Policyholder should list all persons in Section A who are applying for or are now receiving assistance, and are covered by other health insurance, whether or not the policyholder resides in the household.
4. Policyholders completing this form who are not living with enrolled dependents must list in Section A all dependents who get Medicaid or BadgerCare Plus.
5. Use a separate form for each carrier/policy. Ask for additional forms.
6. Once form is completed return to your local county or tribal agency.

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid or BadgerCare Plus but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the Medicaid and BadgerCare Plus programs.

FOR OFFICE USE ONLY			
Casehead Name		Case Number	
TPL Transaction – Information Being ☐Added ☐ Changed or Ended ☐ Deleted		Agency Code	Worker Code

SECTION A –Member

BadgerCare Plus or Medicaid ID Number	Name (Last, First, MI) List all people applying for Medicaid or BadgerCare Plus covered by the policy described in Section C.	Date of Birth (mm/dd/yy)	Relationship to policyholder (check one) 1 – Self, 2 – Spouse, 3 – Child, 4 – Stepchild, 5 - Other
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
			☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SECTION B – Policyholder Information

Type of policy ☐ Major Medical ☐ HMO / HMP / PPO ☐ Medicare Supplement ☐ Accident ☐ Other		Is the Policyholder an Absent Parent? (Parent who is continuously away from the home.) ☐ Yes ☐ No	
Policyholder Name (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yy)	
Policyholder Address – Street	City	State	Zip Code

SECTION C – Insurance Information

Insurance Company Name			
Insurance Company Address - Street	City	State	Zip Code

Policy Number	Policy Start Date (mm/dd/yy)	Policy End Date (mm/dd/yy)	Group Name	Group Number

SECTION D - Employer Information (Complete if Policyholder is Employed)

Employer Name		Telephone Number	
Employer Address - Street	City	State	Zip Code

Should Insurance Claims be sent to the Employer? ☐ Yes ☐ No ☐ Unknown	BadgerCare Plus/Medicaid Program Use Only – Insurance Company or Employer Billing Code

I understand that as a condition of enrollment for Medicaid and/or BadgerCare Plus, I must report to the agency any other person(s) that may be liable to pay for medical care for my family and me. I must also cooperate by giving information to assist the local agency in pursuing payment from any other person(s). I understand that any benefits for the cost of medical care which are available under a policy will be assigned to the State by law (s. 632.72, WI Statutes.) during any period of Medicaid or BadgerCare Plus enrollment. I understand that, within 10 days, I must report any changes in all of the above information. The information given above is true and complete to the best of my knowledge.

SIGNATURE – Policyholder	Telephone Number	Date Signed