*Mississippi*CHIP ENROLLMENT FORM

MISSISSIPPI DIVISION OF MEDICAID

Please complete front and back sections and return this form to the Division of Medicaid (DOM) in the envelope included.

***Indicates required field**

Section 1 Child #1

***MEDICAID/CHIP ID NUMBER OR *SOCIAL SECURITY NUMBER** _____

_____ _____ _____

*LAST NAME (Print) *FIRST NAME (Print) Middle Initial

_____

Address Where You Live City State Zip Code County

_____

*Mailing Address City State Zip Code

(_____)_____ _____/_____/_____ _____

Phone Number (If Available) *Child #1 Birthday (mm/dd/yyyy) Age

What language is spoken in the home?

English ☐ Spanish ☐ Other: _____

Is child pregnant?
(Check one)

☐ Yes
☐ No

Section 1 Child #2

***MEDICAID/CHIP ID NUMBER OR *SOCIAL SECURITY NUMBER** _____

_____ _____ _____

*LAST NAME (Print) *FIRST NAME (Print) Middle Initial

_____

Address Where You Live City State Zip Code County

_____

*Mailing Address City State Zip Code

(_____)_____ _____/_____/_____ _____

Phone Number (If Available) *Child #2 Birthday (mm/dd/yyyy) Age

What language is spoken in the home?

English ☐ Spanish ☐ Other: _____

Is child pregnant?
(Check one)

☐ Yes
☐ No

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***Indicates required field**

Section 1 Child # 3

***MEDICAID/CHIP ID NUMBER OR *SOCIAL SECURITY NUMBER** _____

_____ _____ _____

*LAST NAME (Print) *FIRST NAME (Print) Middle Initial

_____

Address Where You Live City State Zip Code County

_____

*Mailing Address City State Zip Code

(_____)_____ _____/_____/_____ _____

Phone Number (If Available) *Child #3 Birthday (mm/dd/yyyy) Age

What language is spoken in the home?

English ☐ Spanish ☐ Other: _____

Is child pregnant?
(Check one)

☐ Yes
☐ No

Section 2 Coordinated Care Organization (Please choose one)

* Put a check mark by the Coordinated Care Organization (CCO) you want to take care of your child(ren).

☐ Magnolia Health
☐ UnitedHealthcare

Does your child(ren) have a regular primary care physician? ☐ Yes ☐ No

If yes, primary care physician name First _____ Last_____

City: _____ County: _____

Facility Name: _____ Telephone Number: ( ) _____ - _____

Section 3 Your Signature

All information I gave on this form is true and correct. I know that if I get health care from a doctor not in my CCO that I will have to pay.

I have read and understand the information on this application.

_____ _____

*Your signature /or witness DATE

Information that you give is private. Your medical information can only be shared if needed to give medical services. If you get services under the CCO, you give the CCO right to give Medicaid information about your health.