Department of Health and Human Services - **Request for Change of Medicaid Information**

Beneficiary Name: **Medicaid Number / SS Number:** **Date:**

Changes in income or household situation must be reported within 10 days. *Please use the form below to report changes.*

If you need to correct name, date of birth, or gender, please provide the information below:

Personal Information	Name	Date of Birth	Gender

Address and Phone Number	
	Street Address:
	City: County: State: ZIP code:
	Telephone Number:

If anyone has moved in or out of your home, please provide the information below:

Household Changes	Name	Moved		Date of Birth	Social Security Number	Income Source	Disabled		US Citizen	
		In	Out				Yes	No	Yes	No

If you or someone in your household has received a Social Security Number that has not been reported, please provide the information below:

Social Security Number	Name	Social Security Number

Has anyone in your household obtained a job or started receiving income? If so, please provide the information below:

Income	Income Type	Received By	Amount	How Often	Received For

Have you had changes in the amount paid or started paying someone to care for a child or dependent adult? Please provide information below:

Dependent Care Costs	Dependent Care Provider Name, Address, and Telephone Number	Person Being Cared For	How Often	Amount Paid

Have you had changes in your resources? If so, please provide the information below:

Resources	Asset Type	Owned By	Value	Location/Company

Will anyone in your household claim someone on their taxes?

Tax Filing	This Person	Will Claim This Person

Is anyone in your household pregnant or did anyone recently have a baby?

Pregnancy	Name	Expected Due Date	Number of Babies Expected

IMPORTANT: Please read and sign the next page.

I understand that I must report changes in household situation within 10 days. I understand that if I give wrong information, I may have to pay back money for benefits received that should not have been received. I understand when I sign this form that I have told the truth.

I give the Department of Health and Human Services permission to verify, without additional consent from me, information discovered by the department

Signature of Recipient or Authorized Representative Date Telephone

Address of Recipient or Authorized Representative

Return to your information by

Mail:
SCDHHS - Central Mail
PO Box 100101
Columbia, SC 29202-3101

OR

Fax:
(888) 820-1204

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html