OHIO DEPARTMENT OF MEDICAID

HEALTH INSURANCE INFORMATION SHEET

STATE USE ONLY

CARRIER CODE	DOCUMENT NUMBER	MATRIX CODES

SECTION I

(a) County	(b) Agency	(c) Case Number	(d) Case Name *(last, first, initial)*

SECTION II

(A) ☐ Check only if Claim Submission to be billed to employer

(B) Name of Insurance Company	Telephone Number	(C) Name of Employer	Telephone Number
Address		Address	
City, State	Zip	City, State	Zip

(D) ☐ **INDIVIDUAL PLAN** ☐ **GROUP PLAN**

(E) Policy Number	(F) Group Number	(G) Policy Begin Date	(H) Policy End Date	(I) Policy Holder SSN	(J) Policy Holder Name

(K) **POLICY TYPE**		**ADDITIONAL POLICY OPTIONS**		
☐ 1. Medicare Supplemental	☐ 6. Cancer	☐ A. Ambulance	☐ R. Drugs	☐ P. Inpatient
☐ 2. Income (Indemnity) Supplemental	☐ 7. Champus Active	☐ H. Home Health	☐ G. Medical Supply	☐ O. Outpatient
☐ 3. Hospital Surgery	☐ 8. Champus Retire	☐ I. Dental	☐ J. Lab/X-Ray	
☐ 4. Extended Major Medical	☐ 9. Accident Policy	☐ K. Vision	☐ L. Physician	
☐ 5. P.E.R.S.	☐ 10. H.M.O. Policy	☐ N. Nursing Home	☐ Q. Clinic	

SECTION III RECIPIENTS IN POLICY *(Include only those eligible for Medicaid)*

Medicaid Billing Number	Name	Medicaid Billing	Name

SECTION IV MEDICAL SUPPORT ONLY

Date of Court Order	Name of Liable Person	County of Jurisdiction	Place of Employment
Address		Address	
City, State	Zip	City, State	Zip

SECTION V AUTHENTICATION AND INFORMATION RELEASE

I ACKNOWLEDGE THAT I HAVE READ this questionnaire, and I understand its content, purpose and effect and that it is true and correct to the best of my knowledge. I further authorize any person, medical provider, insurance company, or other organization or agency to provide the Ohio Department of Medicaid, upon request, information about me and my family member's health insurance, medical treatment and employment.

Recipient/Guardian Signature	Date	Agency Representative	Date

Submit to: The Ohio Department of Medicaid, Cost Avoidance Unit, Fax Number (614) 728-0757 or e-mail to TPLFAX@medicaid.ohio.gov. Copies should be retained for the submitter's files, Corresponding Agency and Recipient.

INSTRUCTIONS FOR COMPLETING
THE HEALTH INSURANCE INFORMATION SHEET ODM 06612

IF ANY RECIPIENT HAS MORE THAN ONE INSURANCE COVERAGE, AN ODM 06612 FOR EACH POLICY IS REQUIRED.

SECTION I MANDATORY

(a) Insert the county name, (b) Agency Name, (CSEA, Public Assistance, Children Service Board), (c) Case Number (d) Full name (last, first, middle initial)

SECTION II MANDATORY

A. Check only if claim submission is to be billed to employer: check this block when claims are to be sent to the Employer prior to submission to insurance company.

B. Give name and complete address including zip code and phone number of the Insurance Company. This is needed even if claims are to be submitted through Employer.

C. Give name and complete address including zip code and phone number of Policyholder's place of employment.

D. Check the plan type. An individual plan is one in which the Policy Premium is paid directly to the Insurance Company by the Policyholder. A Group Plan is one in which the Policy Premium is paid through the place of employment.

E. Enter the Policy number of the Policy Holder identification number. This number appears on the Medical Identification Card issued by the Insurance Company or Employer. *(Attach a copy)*.

F. Enter the Group Plan number. This number appears on the Medical Identification Card issued by the Insurance Company or Employer *(Include a copy)*.

G. Enter the policy beginning effective period.

H. Enter policy ending effective period. If policy is still active, leave ending date blank. If policy is no longer active, enter policy-ending date. ATTACH VERIFIED DOCUMENTATION FROM INSURANCE COMPANY/EMPLOYER.

I. Enter Policy Holder Social Security Number.

J. Enter the Policy Holder's Name. *(premium payer)*. This will always be an individual.

K. Check Policy Type and/or Additional Policy Options. This represents what services are covered by the insurance.

SECTION III MANDATORY

List the MMIS Billing number twelve (12) digits for each individual.
List the name of all case members who are eligible for Medicaid AND covered on the Insurance Policy.

SECTION IV

IF A RECIPIENT HAS MORE THAN ONE INSURANCE COVERAGE, AN ODM 06612 FOR EACH POLICY IS REQUIRED.

Enter date of Court Order. If this is a modified order you must still enter original Order Date. Enter name of liable person, address *(city, state, zip)*, who is ordered to supply medical coverage.

Enter county of jurisdiction *(where the order is being enforced)*. Enter name, address and phone number of Place of Employment for the liable individual.

SECTION V MANDATORY

1. Obtain the Recipient/Guardian's signature and date. Ensure the recipient understands that this information will be used to recover medical expenses as authorized by the Ohio Revised Code (5160.37 and 5160.38).

2. The agency representative must sign and date form.