

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) <input type="checkbox"/> Check only if Claim Submission to be billed to employer					
(B) Name of Insurance Company		Telephone Number (614)		(C) Name of Employer	
Address		Address		Telephone Number (614)	
City, State		Zip		City, State	
City, State		Zip		Zip	
(D) <input type="checkbox"/> INDIVIDUAL PLAN <input type="checkbox"/> 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		
<input type="checkbox"/> 1. Medicare Supplemental	<input type="checkbox"/> 6. Cancer	<input type="checkbox"/> A. Ambulance	<input type="checkbox"/> R. Drugs	<input type="checkbox"/> P. In Patient	
<input type="checkbox"/> 2. Income (Indemnity) Supplemental	<input type="checkbox"/> 7. Champus Active	<input type="checkbox"/> H. Home Health	<input type="checkbox"/> G. Medical Supply	<input type="checkbox"/> O. Out Patient	
<input type="checkbox"/> 3. Hospital Surgery	<input type="checkbox"/> 8. Champus Retire	<input type="checkbox"/> I. Dental	<input type="checkbox"/> J. Lab/X-Ray		
<input type="checkbox"/> 4. Extended Major Medical	<input type="checkbox"/> 9. Accident Policy	<input type="checkbox"/> K. Vision	<input type="checkbox"/> L. Physician		
<input type="checkbox"/> 5. P.E.R.S.	<input type="checkbox"/> 10. H.M.O. Policy	<input type="checkbox"/> N. Nursing Home	<input type="checkbox"/> Q. Clinic		
SECTION III					
RECIPIENTS IN POLICY (Include only those eligible for Medicaid)					
Medicaid Billing Number		Name		Medicaid Billing Number	
Name		Name		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	

Distribution: **ORIGINAL** to the Ohio Department of Medicaid, Cost Avoidance Unit, P.O. Box 182410, Columbus, Ohio 43218-2410.
COPIES Retain for your files, Corresponding Agency and Recipient

INSTRUCTIONS FOR COMPLETING 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. (Attach 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 (5101:58 and 5101:59).
- 2. The agency representative must sign and date form.