Sample Medical Assistance Renewal Notice

Medical Assistance Renewal Notice

It is time to renew your Medicaid/NC Health Choice coverage.
You can renew your Medicaid/NC Health Choice by mail, by phone, or in person.

Please **provide the requested information and complete this renewal form by:**

- Answering all of the questions on the form
- Adding any missing information
- If any information has changed, writing in the right information.
- Signing the form
- **Return this form by April 30, 2023**
  If you do not return the form by this deadline, you may lose your Medical coverage

We will check your answers using information from computer data sources, including the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

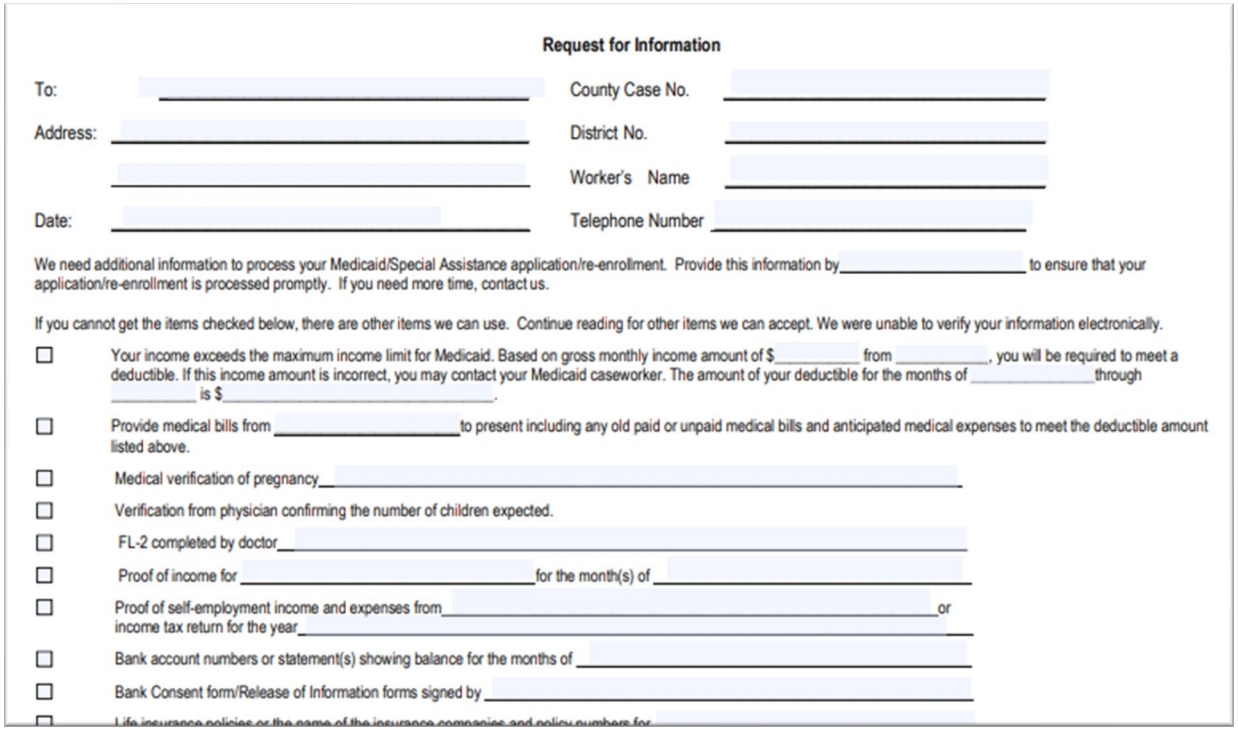
By accepting North Carolina Medicaid/NC Health Choice you understand that the information you give will be checked. You agree to help do that and let the Medicaid/NC Health Choice agency get the information it needs to determine eligibility from government agencies, employers, medical providers, and others. Medicaid/NC Health Choice also has the right to seek money you receive from other sources like insurance payments or lawsuits for services Medicaid has paid for you and your other household members that are receiving a Medicaid/NC Health Choice benefit.

Individuals eligible for Medicaid may be eligible for assistance with transportation to medical appointments.

Contact the Department of Social Services if you have questions, need assistance in obtaining verifications, or need assistance completing this form.

If you are NOT registered to vote where you live now, would you like to register to vote here today?
Y ☐ N ☐

Sample Request for Information Form



Request for Information

To: _____ County Case No. _____

Address: _____ District No. _____

_____ Worker's Name _____

Date: _____ Telephone Number _____

We need additional information to process your Medicaid/Special Assistance application/re-enrollment. Provide this information by_____ to ensure that your application/re-enrollment is processed promptly. If you need more time, contact us.

If you cannot get the items checked below, there are other items we can use. Continue reading for other items we can accept. We were unable to verify your information electronically.

☐ Your income exceeds the maximum income limit for Medicaid. Based on gross monthly income amount of $_____ from _____, you will be required to meet a deductible. If this income amount is incorrect, you may contact your Medicaid caseworker. The amount of your deductible for the months of _____through _____ is $_____.

☐ Provide medical bills from _____to present including any old paid or unpaid medical bills and anticipated medical expenses to meet the deductible amount listed above.

☐ Medical verification of pregnancy_____

☐ Verification from physician confirming the number of children expected.

☐ FL-2 completed by doctor_____

☐ Proof of income for _____for the month(s) of _____

☐ Proof of self-employment income and expenses from_____or income tax return for the year_____

☐ Bank account numbers or statement(s) showing balance for the months of _____

☐ Bank Consent form/Release of Information forms signed by _____

☐ Life insurance policies or the name of the insurance companies and policy numbers for