FAX

Date:	02/11/2026
Pages including cover sheet:	4

To:	
Phone	
Fax Phone	*+19725329272*

From:	Arpit Patel
Phone	+18884110212X701
Fax Phone	+18884110212

NOTE:

Packet Routing Fax from PG : To: 19725329272, referenced id: 705154

Ohio Department of Medicaid

REPORT A CHANGE FOR MEDICAL ASSISTANCE

Use this form to report any changes for yourself or for someone else. Individual Information at the top of the form and Submitter Information at the bottom of the form must be completed. The Submitter Information means the person who sends this form to the CDJFS. You may need to provide additional paperwork such as a lease, insurance policy, or bank statement to show the reported change is accurate.

INDIVIDUAL INFORMATION - Complete this section for the individual receiving medical assistance. *Indicates required field

*First Name	*Last Name	Middle Initial	*DOB
client	registered		11/11/2010

Medicaid Case Number	*Social Security Number
545466	112-22-3340
***Effective Date of Change** *(mm/dd/yyyy)*	**Authorized Representative** *(print)*
02/10/2026	Corporate Admin

CHANGE NOTIFICATIONS – Check the box if there has been a change in information. Only complete the sections below where information has changed.

☑ **Phone Number Change**

New Phone Number
(443) 454-5454

☐ **Address Change**

New Street Address				Building/Unit Number
City	State	Zip Code	Phone	County
			(453) 554-3545	

☐ **Change In Number Of People Who Live With You (or Individual)**

List each person and if they live with you *(if more than two household member updates, please enter additional information in the comments section on the next page).*

Name:	*Name:*
Relationship:	*Relationship:*
Date of Birth:	*Date of Birth:*
Social Security Number:	*Social Security Number:*
Income:	*Income:*
☐ *Lives with me (or individual)* ☐ *No longer lives with me*	☐ *Lives with me (or individual)* ☐ *No longer lives with me*

☐ **Change of Marital Status**

☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name

☐ **Pregnancy**

Are you pregnant? ☐ Yes ☐ No	Number of Unborn Babies	Expected Due Date *(mm/dd/yyyy)*	Delivery Date *(mm/dd/yyyy)*
			Newborn Name

☐ **Change in Income and/or Work Status***(attach verification such as receipt, title, or bank statement)*

☐ Income Increase ☐ Income Decrease	Income Amount and Income Source
☐ New Job ☐ Loss of Job ☐ Change to Part-time job status ☐ Change to Full-time job status	

Type of One-time Payment Received *(e.g. Backdated Social Security payment, sale of home/property, insurance payment, winnings,etc.)*	
Amount of One-time Payment or Lump Sum Received $	Date One-time Payment or Lump Sum Received *(mm/dd/yyyy)*

☐ **Change in Resources**

☐ Life Insurance Policy *(attach policy for verification)* ☐ Checking/Savings Account *Last four digits of account number:* *Amount in account: $* ☐ Other *(attach verification)*	☐ Vehicle *Year and Make:* *Model:* ☐ Property *Address:* *Value of Property:*
PNA (Personal Needs Allowance) Account Balance Amount	

☐ **Change of Insurance** *(select all that apply and respond to supplemental insurance questions when applicable)*

☐ New coverage under health insurance policy
Name of Insurance Company:
Coverage Type:
Policy Number:
Begin Date:
Monthly Premium:

☐ Loss/End of Insurance Coverage
Name of Insurance Company:
End Date:

☐ Accident or injury for which another person or entity may be responsible *(e.g. auto accident, workman's comp)*
Name of Company:
Coverage Type:
Policy Number:
Date of Incident:

☐ Court order requiring a person or entity to pay some or all of my (or the individual's) medical expenses *(e.g. divorce, custody, auto accident, civil suite, e.g.)*
☐ Court Order Attached *(must be submitted for verification)*
Date of Court Order:

☐ Change in health insurer(s)
☐ Medicare
Medicare Type (A,B C, or D):
Begin Date:
Medicare Number:
Monthly Premium:

☐ Private Insurance
Name:
Begin Date:
Policy Number:
Monthly Premium:

☐ Other: _____

Any other Changes to Report:

Comments:

SUBMITTER INFORMATION: Read and Sign

- **I'm signing this form under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.**
- **I know that I must tell the Ohio Department of Medicaid if anything changes (and is different than) what I wrote on this form. I can call 1-800-324-8680 to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) of my household.**
- **I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.**

***Submitter Name** *(Print First and Last)*	***Date** *(mm/dd/yyyy)*	***Phone** (__)___-____
Corporate Admin	02/10/2026	(121) 212-2121

***Submitter Signature** *(First and Last)*
Corporate Admin

***Relationship to Individual**
Consultant