MISSISSIPPI COORDINATED CARE ENROLLMENT FORM

Mississippi Medicaid Program
MSCAN Enrollment
P.O. Box 23078
Jackson, MS 39225
Phone: 1-800-884-3222
Fax: 601-206-3015
http://www.medicaid.ms.gov/

Asterisk (*) denotes required fields

Section 1: Personal Information

* Medicaid ID/Social Security Number:

* Last Name | * First Name | * MI

Address Where You Live:

*Street: | *City: | *State

*Zip and Extension | County

-

Mailing Address: (If Different):

Street: | City: | State

Zip and Extension | County

-

Your Telephone Number: (If Available) | Your Birthday: (mm/dd/yyyy) | Age | *Are You Pregnant?

Yes No

*What language is spoken in your home? English Spanish Other

*Other Language

Section 2: Coordinated Care Organization (Please choose one)

*Choose the Coordinated Care Organization (CCO) you want to take care of your health.

Magnolia Health

Molina HealthCare

United HealthCare

*Do you have a regular primary care physician? Yes No

Regular primary care physician details:

Last Name	First Name	Facility Name
City	County	Telephone

Section 3: Your Signature

*All information I gave on this form is true and correct. I know that if I get health care from a doctor not in my CCO that I will have to pay.
I have read and understand the information on this application.

*Name of the Person submitting the form: *Date:

Information that you give is private. Your medical information can only be shared if needed to give medical services. If you receive services under the CCO, you give the CCO right to give Medicaid information about your health.