LOUISIANA DEPARTMENT OF HEALTH
Medicaid

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MEDICAID MEMBER CLOSURE REQUEST FORM

VERIFY YOUR INFORMATION:			
Name:			SSN or Medicaid Case ID:
HOME ADDRESS: *(optional)*	Street Address:		Apt/Suite Number:
	City:	State:	ZIP Code:
MAILING ADDRESS: *(optional)*	Street Address:		Apt/Suite Number:
	City:	State:	ZIP Code:

MEMBERS TO BE CLOSED:	
Provide the name and date of birth for everyone in this case that needs to be closed.	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:

If you need more space for member information, please fill out an additional form and include it with this submission.

SIGN THIS FORM:

By signing this form, I am giving my permission to the State of Louisiana and its agents to verify the information given on this form. Under penalty of perjury, I certify that all information contained in this form is true and correct to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____

Must be signed by hand. Digital or electronic signature will not be accepted.

FORMS MAY BE SUBMITTED:

By email to **MyMedicaid@la.gov**
By mail to **Louisiana Medicaid/LaCHIP, P.O. Box 91283, Baton Rouge, LA 70821-9278**
By fax to **1-877-523-2987**