Medicaid Renewal: Claim Form

Please complete this form if your Medicaid Coverage has been terminated or will be terminated soon and you did not receive advance written notice or the advance written notice incorrectly said you failed to submit a required form or documents.

Your Name (*first, middle, last*)

_____

Social Security Number/ Medicaid Number Date of Birth *(mm/dd/yyyy)*

_____

Home Address (*Check here if you are homeless*) ☐

_____

City State Zip Code

_____

Mailing Address (If different from your home address)

_____

City State Zip Code

Since your last renewal, have you moved or changed your mailing address? Yes ☐ No ☐

If yes, date of your move or change of mailing address: _____

Phone number (*if you have one*)_____ Email address (*if you have one*) _____

If additional household members renewed their Medicaid Coverage, please list them here. Tell us the name (first and last), Social Security Number (SSN) or Medicaid (MA) ID Number and Date of Birth (DOB) of those household members.

Name_____ SSN or MA# _____ DOB _____
Name_____ SSN or MA# _____ DOB _____
Name_____ SSN or MA# _____ DOB _____

_____

Read each statement below and check the box (true or false) that applies to your circumstance

True ☐ False ☐ I receive DC Medicaid.

True ☐ False ☐ I did not receive my Medicaid renewal form.

True ☐ False ☐ I have submitted my Medicaid renewal form

True ☐ False ☐ I did not receive any notice(s) informing me of an outstanding verification(s).

True ☐ False ☐ I have submitted the requested verification(s)

True ☐ False ☐ I have not received a determination notice for DC Medicaid coverage.

Please sign and date below.

I have reviewed the information in this renewal claim form and I attest under penalty of perjury that it is true and correct. I understand if I willfully state that any material matter is true and I do not believe that it is true and it is in fact untrue, I may be subject to a fine, imprisonment, or both for perjury as described in D.C. Official Code § 22-2402 or false swearing as described in D.C. Official Code § 22-2405. I may also be subject to criminal and civil penalties for committing fraud in a public assistance program which could include repayment of benefits, fines, imprisonment, or all of the above as described in D.C. Official Code §§ 4-218.01, 4-218.02.

If you want an authorized representative or want to change the authorized representative, you have now, please call 1-855-532-5465 (TTY:711).

☐ Check here if you are an authorized representative. Do not forget to sign below.

Signature_____ Date_____

Print Name_____

Ways to submit your claim:

You can submit your completed claim form by fax, email or in person at a Service Center near you. If you wish to submit a claim by phone, you may call the Department of Human Services (DHS) Call Center.

By Email: DPO.Deputy@dc.gov
By Fax: 202.535.1122
By Phone: 202.727.5355
In person:

H Street Service Center
645 H St., NE
Washington, DC 20002

Anacostia Service Center
2100 Martin Luther King Ave., SE
Washington, DC 20020

Taylor Street Service Center
1207 Taylor St., NW
Washington, DC 20011

Congress Heights Service Center
4001 South Capitol St., SW
Washington, DC 20032

Fort Davis Service Center
3851 Alabama Ave., SE
Washington, DC 20020