DMA – 410: EB-TPL

ICN:

DEPARTMENT OF COMMUNITY HEALTH – DIVISION OF MEDICAL ASSISTANCE
COB NOTIFICATION FORM

Member Name: _____ **Medicaid ID#:** _____

I. CO-PAYMENT NOTIFICATION

No EOB Available. Coverage is through: _____
Insurance / benefit plan. The co-payment for their service is _____

II. COB NON-COVERAGE AFFIDAVIT

I submitted my claim(s) to _____ ***(Insurance Carrier)*** on _____ ***(date)*** for payment. After receiving no response, I contacted the carrier on _____ ***(date)*** for confirmation.

Insurance Representative: _____ Telephone #: _____

☐ Insurance was cancelled on _____ **(date)**

☐ Service is non-covered, annual/lifetime service limits exceeded.

☐ Member not covered under this policy.

☐ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).

☐ Other (explain) _____

_____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

Signature of Patient Account Representative	**Date**	**Provider #**

Note: This statement must be in accordance with the provisions of Part 1, Policies and Procedures, Chapter 200 – Timely Submission, Section 202.2(b).

Attach this form to your claim(s) submitted electronically.

III. COB INFORMATION UPDATE

When updating the COB Information only, upload member's information and a scanned image of the member's insurance card via the GAMMIS Web Portal at www.mmis.georgia.gov.

THIS FORM MAY BE PHOTOCOPIED

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