This document is being provided in an alternate format (large print, audio or data CD, or Braille) for informational purposes only. Any documents that need to be completed and returned must be completed and returned in written, non-alternative format.

DOH-5104 (5/14)

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Enrollment and Exchange

Information Concerning Medical Assistance For SSI/SSP Beneficiaries

Please Print Clearly

NAME (first, middle initial and last) ____
SOCIAL SECURITY NO. ____
DATE OF BIRTH (month/day/year) ____
SEX
☐ Male

☐ Female
RESIDENCE ADDRESS ____
CITY ____
ZIP CODE ____
TELEPHONE NUMBER ____
MAILING ADDRESS (if different from above) ____
CITY ____
ZIP CODE ____

Medicare

Do you have a red, white and blue card from the Social Security Office?

☐ Yes *
☐ No
* If Yes, Claim Number ____
Effective Date: (As appears on your red, white and blue card) ____

HOSPITAL INSURANCE ____
MEDICAL INSURANCE ____
Do you have health insurance other than Medicaid or Medicare?

☐ Yes
☐ No
If yes, complete.

1. Insurance Company ____

Effective Date ____
Policy No. ____
Group No. ____
Policy Holder Name ____
Employer/Union Name ____
Monthly Cost ____

2. Insurance Company ____
   Effective Date ____
   Policy No. ____
   Group No. ____
   Policy Holder Name ____
   Employer/Union Name ____
   Monthly Cost ____

Do you have medical bills from 3 months before you applied for SSI/SSP up until now?

☐ Yes
☐ No

If yes, list below:

Date of Service ____
Doctor/Hospital/Pharmacy/Other ____
Amount ____

NON-DISCRIMATION NOTICE–The information will be considered without regard to race, marital status, sex, handicaps, religion, ethnic background, national origin, political beliefs or age.

CHANGES–I agree to inform the agency promptly of any change in the above to the best of my knowledge or belief.

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS–I will file any claims for health or accident insurance benefits or any other resources to which I am entitled, and do hereby assign any such resources to the Social Services official to whom this information is provided. In addition, I will assist in making any required assignment of benefits or resources to the Social Services official to whom this form is directed.

DIRECT PAYMENT–I authorize the payment of my health or accident insurance benefits to be made directly to the appropriate Social Services official for medical and other health services furnished while I am eligible for Medical Assistance.

MEDICARE–I authorize the payment under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

INFORMATION REGARDING LIENS AND RECOVERIES–If you receive Medical Assistance, a lien

may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. However, no lien will be filed against your home if one of the following persons is living there: your spouse; your child who is under age 21 or who is certified blind or disabled; your brother or sister, if he or she has a right to part of your home and lived there for a least one year immediately before you went into the medical institution. In addition, any lien placed against your real property will be removed if you return home from the institution.

A recovery may be made from your estate for Medical Assistance you received when you were 55 years of age or older. However, no such recovery will be made at a time when you are survived by your spouse or by a child who is under age 21 or who is certified blind or disabled.

Medical Assistance paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained.

SSI/SSP BENEFICIARY/REPRESENTATIVE SIGNATURE
X ____
DATE SIGNED ____
HUSBAND/WIFE PROTECTIVE REPRESENTATIVE X
____

DATE SIGNED ____

PLEASE READ THIS FORM CAREFULLY AND BE SURE TO SIGN YOUR NAME.

RETURN THIS FORM AND THE ENCLOSED LETTER TO YOUR LOCAL SOCIAL SERVICES DISTRICT OFFICE.