

Name: _____

Medicaid ID#: _____

Traditional or Expansion*: _____

Medicaid Redetermination Date: _____

1915(i) Start Date: _____

1915(i) End Date: _____

*If the individual has Expansion Medicaid, their ID number must be requested through Availity.

Eligibility information is subject to change. This information was provided and verified as accurate on the following date: _____