**NATIONAL MEDICAL SUPPORT NOTICE – ADDENDUM TO PART-B**

|  |  |  |  |
| --- | --- | --- | --- |
| Issuing Agency: |  | Court or Administrative Authority: |  |
| Issuing Agency Address: |  | Order Date: |  |
| Notice Date: |  | Order Identifier: |  |
| CSE Agency Case Identifier: |  | Document Tracking Identifier: |  |
| Telephone Number: |  | Employer web site: |  |
| FAX Number: |  | See NMSN Instructions: |  |
|  |  | <http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form> | |

**SECTION 1: HEALTH INSURANCE DETAILS**

Use section 1-1 through 1-6 to provide the provider, policy and group numbers of the plans child (ren) is/are enrolled.

**SECTION 1-1: MEDICAL INSURANCE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | |  | | |  | | | | |  |  |
| Insurance Provider Name | | | | | |  | | | Group Number | | | | |  | Policy Number |
|  | | | | | |  | | |  | | | | |  |  |
| Insurance Provider Address Line 1 | | | | | |  | | | Insurance Provider Address Line 2 | | | | |  |  |
|  | | | | | |  | | |  | |  | | |  |  |
| Insurance Provider City | | | | | | State | | | Zip Code | | Zip Code Ext | | |  |  |
| Medical Insurance Coverage also Includes: (Check all that apply) | | | | | | | | | | | | | |  |  |
|  | Dental |  | Vision |  | Prescription | |  | Mental Health | |  | | Other (Specify): |  |  |  |

**SECTION 1-2: DENTAL INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | |  |  |
| Insurance Provider Name |  | Group Number | |  | Policy Number |
|  |  |  | |  |  |
| Insurance Provider Address Line 1 |  | Insurance Provider Address Line 2 | |  |  |
|  |  |  |  |  |  |
| Insurance Provider City | State | Zip Code | Zip Code Ext |  |  |

**SECTION 1-3: VISION INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | |  |  |
| Insurance Provider Name |  | Group Number | |  | Policy Number |
|  |  |  | |  |  |
| Insurance Provider Address Line 1 |  | Insurance Provider Address Line 2 | |  |  |
|  |  |  |  |  |  |
| Insurance Provider City | State | Zip Code | Zip Code Ext |  |  |

**SECTION 1-4: PRESCRIPTION DRUG INSURANCE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  |  | | | |  |  | |
| Insurance Provider Name | |  | Group Number | | | |  | Policy Number | |
|  | |  |  | | | |  |  | |
| Insurance Provider Address Line 1 | |  | Insurance Provider Address Line 2 | | | |  |  | |
|  | |  |  | |  | |  |  | |
| Insurance Provider City | | State | Zip Code | | Zip Code Ext | |  |  | |
|  |  | | |  | |  | | |

**SECTION 1-5: MENTAL HEALTH INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | |  |  |
| Insurance Provider Name |  | Group Number | |  | Policy Number |
|  |  |  | |  |  |
| Insurance Provider Address Line 1 |  | Insurance Provider Address Line 2 | |  |  |
|  |  |  |  |  |  |
| Insurance Provider City | State | Zip Code | Zip Code Ext |  |  |

**SECTION 1-6: OTHER INSURANCE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  |  | | | |  |  | |
| Insurance Provider Name | |  | Group Number | | | |  | Policy Number | |
|  | |  |  | | | |  |  | |
| Insurance Provider Address Line 1 | |  | Insurance Provider Address Line 2 | | | |  |  | |
|  | |  |  | |  | |  |  | |
| Insurance Provider City | | State | Zip Code | | Zip Code Ext | |  |  | |
|  |  | | |  | |  | | |

**SECTION 2: NO LONGER ELIGIBLE CHILDREN DETAILS**

Use below section to list child(ren) who are at or above the age at which dependents are no longer eligible for coverage under the plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  **(Last, First, Middle)** | **Gender** | **Date of Birth** | **Social Security Number** |
|  |  |  |  |
|  |  |  |  |
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