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**