# 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** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |