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)	**Sex**	**Date of Birth**	**Social Security Number**