

### Request for Forced Change of Medical Coverage

**TO: SDX/Medical Eligibility Unit  
Data Integrity Section  
State Office 952-X**

**FROM:** \_\_\_\_\_  
\_\_\_\_\_  
Address Mail Code

Case No.	Case Name	Category	Type Program
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Client No.	Client Name	Requested Medical Coverage		File Date for Requested Med.
		Begin Date	End Date	

**Reason(s) for Request:**

- Hearing Officer Decision (Attach copy of Form H4807, Official Record of Fair Hearing.)
- Three Months Prior Was Not Processed with Application for Ongoing Benefits
- Initial Coverage Was Not Provided from the Application Month
- Other (explain):

\_\_\_\_\_ Signature – Worker \_\_\_\_\_ Date

Worker Name (please print or type)	BJN	Telephone No. (inc. A/C or STS)
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**Data Integrity Response**

Medical coverage was provided as requested on..... \_\_\_\_\_  
Date

Please advise providers to resubmit claims marked "delayed billing" and to indicate the date coverage was added to the file.

Comments: \_\_\_\_\_

\_\_\_\_\_ Signature – Data Integrity Staff \_\_\_\_\_ Date

Send original and one copy to Data Integrity; one copy to file.