

Medicaid Problem Report Sheet

Date of Report:

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|--|--|---------------------|
| Consumer Name: | Medicaid Number: | Date of Birth: |
| Address: | | County: |
| Name of Contact Person: | Contact Person's Telephone: | Email: |
| Relationship to Consumer: | | |
| Name of Medicaid HMO: | Medicaid HMO Number: | Date of Enrollment: |
| Does Consumer have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No | Private Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Private Insurance Company: | |
| Brief Description of Consumer's Diagnosis/Health Issues: | | |
| | | |
| Brief Description of Problem: | | |
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| Medication co-pay problem? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, name of medication(s): | |
| Covered under Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No | Medicare Part D drug plan: | |
| Covered Under Private Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Insurance Company: | |
| Brief Description of the Medication Co-pay problem: | | |
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| If problem is with the medication co-pay, name and phone number of pharmacy: | | |
| | | |
| Have you contacted a Medicaid HMO Care Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Care manager (if known) and brief description of what happened: | | |
| | | |
| I give permission for this information to be forwarded to The Arc of New Jersey, and also give permission for it to be forwarded to the NJ Division of Medical Assistance and Health Services (NJ Medicaid). | | |
| *Signature: | | Date: |
| | | |

Please email this completed form to Beverly Roberts at broberts@arcnj.org or to Helen Rivera at hrivera@arcnj.org. The form may also be faxed to (732) 214-1834. We will get back to you as soon as possible.

**Electronic Signature accepted: Typed signature with date indicates electronic verification of the information provided.*