State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO RECIPIENT CONFLICTING DATA REPORT

Return this form to: HealthChoice, Beneficiary Enrollment Services, Room L-9
201 W. Preston Street, Baltimore, MD 21201

Date: _____

MCO Name: United HealthCare ▼

MCO Representative: _____ Phone: _____

Member Name: _____
Last First M.I.

Member Medical Assistance #: _____

(Check appropriate box in Part I and provide detailed information in Part II)

Part I **This information pertains to:**

Name: ☐ SSN: ☐ DOB: ☐ Gender: ☐ HOH Change: ☐ Phone Number: ☐

Date of Death (include Place of Death): ☐ Incarceration (include Phone #/Name of Facility): ☐

Other: _____

Part II **Reported information needing verification:**

_____

_____

(To be filled out by DHMH and forwarded to DSS)

TO: Local Department of Social Services Date: _____

RE: An MCO has notified us of conflicting data for the Medical Assistance recipient listed above. Please verify the information and make the appropriate corrections on their record.

Information per MMIS-II:

_____

_____

_____

CARES Information:

_____

_____

_____

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