

Date: _____
BG #: _____
HH #: _____
Case Name: _____

South Carolina Medicaid Program Annual Review Form

This form is used to review your Medicaid coverage.

You must return this form to us by _____

Return to: SCDHHS, PO Box 100101, Columbia, SC 29202

- If you do not return this form, your Medicaid will stop. This could affect the amount of your Social Security benefit.
- If you do not return proof of your income and resources, we cannot continue your Medicaid.
- Please fill out EACH item on this form. If an item does not apply, write "does not apply."
- If an answer to any question is none or 0, write "none".

If you need help filling out this form, call Healthy Connections at (888) 549-0820.
Si necesita ayuda para llenar este formulario, puede llamar.

What language do you use most? ☐ English ☐ Spanish ☐ Other (specify) _____

I. Fill out the following information about the beneficiary:

Last Name		First Name			Middle Initial
Mailing Address (Include Apartment/Lot Number)		City	County	State	Zip Code
Street Address, if different (Include Apartment/ Lot Number)		City	County	State	Zip Code
Telephone Number where we can reach you, including area code Phone # () Second Phone # ()				FOR AGENCY USE Date Received: _____	

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number: _____
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South Carolina Medicaid Policy Procedure Manual

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