

RECIPIENT INSTRUCTIONS:

This Chronic and Acute Medical Assistance (CAMA) Recipient Identification Card is only valid for the month and year indicated on the card. It can be used only by the individual listed on the card and only to receive authorized medical services from health care providers who are enrolled to use the Alaska Medicaid Health Enterprise. To protect yourself from payment liability, you must present this card to your health care provider before obtaining services. Verify with your provider that the services you need are covered by CAMA. At the time of service, your provider will make a copy of this card or record your I.D. number. Keep this card with you for future use. Obtain a receipt from the provider that shows you identified yourself as a CAMA recipient. This I.D. card is only valid in Alaska, unless an out-of-state service has been prior authorized.

If you have private medical insurance available, you are responsible for providing all policy information to your health care provider and to CAMA. You are responsible for meeting all service authorization requirements of your private insurance. Failure to do so may mean you pay the bill. Use of this card constitutes your consent for inspection of your medical records by representatives of the State and Federal Government. You must fully cooperate with CAMA reimbursement in subrogation cases.

INTENTIONAL MISUSE OF THIS RECIPIENT IDENTIFICATION CARD IS UNLAWFUL AND THE OFFENDER WILL BE LIABLE TO PENALTY.

G181124

RECIPIENT IDENTIFICATION CARD		STATE OF ALASKA			MEDICAL ASSISTANCE PROGRAM			
NAME OF ELIGIBLE PERSON(S)	CLIENT I.D. NO.	BIG. MONTH	D.O.B.	SUB-TYPE	E.C.	RESOURCES	MEDICARE	
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	0125	0653	SL	78	J ** **	XXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXX	0000	**	**	** ** *	XXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXX	0000	**	**	** ** *	XXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXX	0000	**	**	** ** *	XXXXXXXXXXXX	

****AUTHORIZATION STATEMENT****

FOR RECORD PURPOSES ONLY. NOT VALID FOR MEDICAID SERVICES. THIS AUTHORIZES THE STATE OF ALASKA TO PAY ONLY THE MEDICARE PART B PREMIUM FOR THE PERSON/S LISTED ABOVE

HEALTH CARE PROVIDER INSTRUCTIONS: THIS CARD IDENTIFIES THE PERSON LISTED ABOVE AS A CAMA RECIPIENT WHO IS ELIGIBLE TO RECEIVE MEDICAL ASSISTANCE FROM HEALTH CARE PROVIDERS ENROLLED TO USE THE ALASKA MEDICAID HEALTH ENTERPRISE. PROVIDERS MUST VERIFY THAT THE BEARER OF THIS CARD IS THE NAMED PERSON AND WRITE THE CLIENT I.D. NUMBER ON OR ATTACH THE IDENTIFICATION CARD TO EACH CLAIM.

NOTE: Cooperation with third party resources includes supplying your provider with medical insurance coverage information such as detailed information. Providers must accept payment from all resources prior to billing CAMA.

SEE REVERSE SIDE FOR
OPENING INSTRUCTIONS

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OPENING INSTRUCTIONS

07123219 10137370

RETURN SERVICE REQUESTED

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
P.O. BOX 240127
ANCHORAGE, ALASKA 99524-0127

POSTNET
FIRST-CLASS MAIL
U.S. POSTAGE
PAID
ANCHORAGE, AK
PERMIT No. 181

MEDICAL ASSISTANCE RECIPIENT HELPLINE 1-800-780-9972 (Statewide)
1-907-644-6800 option 6 (Anchorage)

HEALTH CARE PROVIDER INFORMATION

Eligibility Verification

Enrolled Providers	1-800-884-3223 (EVS)
Non-enrolled Providers	1-800-770-5650 (Statewide) 1-907-644-6800 (Anchorage/Out of State)

Coverage Inquiries	1-800-770-5650 option #1 (Statewide) 1-907-644-6800 option #1 (Anchorage/Out of State)
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Submit claims to:	Xerox State Healthcare, LLC P.O. Box 240769 Anchorage, Alaska 99524-0769
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CLAIMS WILL NOT BE PAID IF THE PROVIDER IS NOT ENROLLED TO USE
THE ALASKA MEDICAID HEALTH ENTERPRISE

REMOVE SIDE EDGES FIRST
THEN FOLD, CREASE AND TEAR ALONG PERFORATION

REMOVE THESE SIDE EDGES FIRST
FOLD, CREASE AND TEAR ALONG PERFORATION

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