

# 590 Program Enrollment/Discharge/Transfer (EDT)

State Form 32696 (R \_\_\_\_\_) / OMPP 0747

Please check one: New enrollment _____ Update _____	Is individual currently on Medicaid? Yes _____ No _____ If Yes, enter RID number: _____
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<i>Sections I, II, &amp; III are to be completed by institutional facility</i>				
<b>I. New Enrollment Information</b> (only for first-time enrollments, updates should be entered in section III below)				
1 Entrance date	2 Last name	3 First name	4 Middle initial	
5 Name of institutional facility				
6 Street				
7 City	8 State	9 ZIP code	10 Date of birth	
11 Race: White _____ Black _____ Asian _____ American Indian _____ Multiracial _____ Other _____			12 Sex Male _____ Female _____	
13 DOC or DMH/DDARS number	14 Social Security number (required)	15 Medicare number	16 Medicare effective date	
<b>II. Other Health Insurance</b>				
17 Name of policy holder		18 Relationship		
19 Name of policy	20 Policy number	21 Type of insurance	22 Start date	23 Stop date
19 Name of policy	20 Policy number	21 Type of insurance	22 Start date	23 Stop date
<b>III. Enrollment Update Information</b>				
24 Date of death	25 Date of release	26 Date of parole	27 (intentionally left blank for future use)	
28 Date of transfer	29 Name of institution being transferred from		30. Name of institution being transferred to	

<i>To be completed by Indiana Medicaid</i>			
Original enrollment	RID	Start date	Stop date
Update	RID	Start date	Stop date