SNT BENEFICIARY DEATH NOTIFICATION FORM

Member's Name: _____

Medicaid ID / SSN: _____

Date of Death: _____

Member's Address: _____

_____

Name of Authorized Representative: _____

Address of Authorized Representative: _____

_____

Contact Phone Number: _____

Has Probate been filed? ___Yes ___No **County:** _____

Estate Number: _____

Submitted by: ___ Trustee ___Personal Representative (__Executor ___ Administrator)
___ Attorney ___Other

Attorney: _____

Address: _____

Telephone: _____ **Fax**: _____

Email: _____

Forward to:

Georgia Department of Community Health
Attn: Trust Unit
900 Circle 75 Parkway
Suite 650
Atlanta, Georgia 30339
Telephone: (678) 564-1168 Fax: (678) 564-1169

www.hms.com/ga.medicaidrecovery