The Arc of New Jersey Health Care Advocacy
Medicaid Problem Report Form

Date of Report:

Consumer Name:	Medicaid Number:	Date of Birth:
Address:		Age:
Name of Contact Person: Relationship to Consumer:	Contact Person's Telephone:	Email:
Name of Medicaid HMO:	Medicaid HMO Number:	County:
Does Consumer have Medicare? ☐Yes ☐No	Private Health Insurance? ☐Yes ☐No Name of Private Insurance Company:	
Brief Description of Consumer's Diagnosis/Health Issues:		
Brief Description of Problem:		
Medication co-pay problem? ☐Yes ☐No	If yes, name of medication(s):	
Covered under Medicare Part D? ☐Yes ☐No	Medicare Part D drug plan:	
Brief Description of the Medication Co-pay problem:		
If problem is with the medication co-pay, name and phone number of pharmacy:		
Have you contacted a Medicaid HMO Care Manager? ☐Yes ☐No If yes, name of Care manager (if known) and brief description of what happened:		
Additional Comments:		
I give permission for this information to be forwarded to The Arc of New Jersey, and also give permission for it to be forwarded to the NJ Division of Medical Assistance and Health Services (NJ Medicaid).		
*Signature:		Date:

Please email or fax this completed form to Connor Griffin at cgriffin@arcnj.org / fax (732) 246-2567. We will get back to you as soon as possible.

**Electronic Signature accepted: Typed signature with date indicates electronic verification of the information provided.*