For North Carolina Medicaid Recipients Only

Students: Please complete **Section I** and return by fax, email, or in person to
Office of Student Accounts
Race Hall, 1st Floor
(336) 517-2121 phone
(336) 517-2113 fax
StudentHealthCenter@bennett.edu
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SECTION I
I am requesting that you provide Bennett College the information in Section II below.

Print Name: ____

Medicaid Recipient ID Number: ____________________________

Date of Birth: ____

Signature: ____

Date: ____

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SECTION II

FOR OFFICE USE ONLY

NC Department of Health and Human Services
Attn: Ms. Ekia Knight, Division of Medical Assistance Recipient and Provider Services
Fax Numbers: (919) 715-5235 or (919) 715-0844

BENEFIT EXPIRATION DATE: ___________________________

Please indicate if coverage is limited. (ex. family planning only)

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Please Fax this information to: (336) 517-2113