



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 www.mass.gov/masshealth

MassHealth Enrollment Center
 333 Bridge Street
 Springfield, MA 01103
 413-785-4100 or 1-800-332-5545
 TTY: 1-800-596-1276
 Fax: 413-785-4180

Financial Information Request

Name: _____ Social security number: _____

Address: _____ City/Town/Zip: _____

Name of financial institution: _____

Address: _____ City/Town/Zip: _____

You or your spouse have applied for MassHealth. You must get a copy of your bank accounts to us so we can complete the application process. If you do not have your account records, you can get them from your bank.

Sometimes, banks charge a fee to get these records. You can get them at **no cost** with this form.

You need to complete one form for each bank where you have accounts.

- Complete the top of this form (**PLEASE PRINT** your name, address, and social security number and the name and address of the financial institution).
- In **Section 1**, list the account number and time period that you need the bank records for.
- In **Section 2**, tell the bank where you want the information sent (to you or to the MassHealth Enrollment Center listed above).
- Sign and date the form before you give it to your bank.
- Bring or mail the form to the bank.

Pursuant to M.G.L Ch. 118E, § 23A, please provide, without charge, the deposit and withdrawal records for the accounts and time periods listed below for the above-named MassHealth (Medicaid) applicant, member, or spouse of an applicant or member.

Section 1

Account number: _____ Time period: _____

Account number: _____ Time period: _____

Account number: _____ Time period: _____

Section 2

Within two weeks of your receipt of this request, please send that information to:

- the above-named MassHealth applicant or member; or
- the MassHealth Enrollment Center listed above.

 Signature of MassHealth Applicant/Member or Spouse

 Date

MassHealth Signature *Russell Kulp*