Client ID #_____

Contract Number:
Patient:
Claim Number:
Date of Service:

Dear:

Before we can process your claim, we need to know if you, your spouse or your dependents are currently covered by another health insurance company. Therefore, complete the form below and return this letter to us in the enclosed envelope **within 14 days to avoid unnecessary denial of this claim.** To protect your privacy and properly update your membership file, we regret that we cannot accept this information by phone. Thank you

1. Do you or any member of your family have health care insurance with another company?

_____ Yes – Family coverage _____ Yes – Single coverage _____ No
Spouse's birthdate _____

2. If spouse's coverage has terminated, please provide cancellation date. _____

3. Do you or any member of your family have Medicare Part A coverage? _____ Yes _____ No
Medicare part B coverage? _____ Yes _____ No

4. Is the patient a dependent child whose natural parents are divorced or separated? _____ Yes _____ No
If "Yes", give the name of the parent ordered by the court to maintain health care as "Name of Insured" in the section below and attach a copy of the court order.

If you answered "Yes" to any of these questions, please fill out the following regarding the other insurance:

Name of Insured _____ Birthdate _____ Social Security Number _____
Employer, Union or Sponsoring Organization of Insured _____
Effective Date _____ Cancelled Date _____ Employment Status _____ Active _____ Retired
Employer's Street Address _____
Employer's City, State, Zip Code _____
Insurance Company Name _____ Policy Number _____
Insurance Company's Street Address _____
Insurance Company's City, State, Zip Code _____
Insurance Company's Phone Number _____

I hereby certify the above statements are true and correct to the best of my knowledge, and authorize any insurance company, employer, or hospital to release all information with respect to myself and any of my dependents which may affect the benefits under this or any other plan providing benefits or services.

_____ _____
Your Signature Date