Employee questionnaire:
Request for other medical insurance information

This form is submitted to inform us of all medical insurance coverage available to you. If you have other insurance in addition to your coverage from HealthSCOPE Benefits, we will need your other insurance information. By coordinating benefits with all insurance carriers, the insured receives the maximum benefits available.

Important: Your response is required. Failure to provide the information requested on this form may delay the processing of your medical claims. **Please respond even if you have no other medical insurance coverage.**

You can provide this information in one of 4 ways:

- Call the number on your ID card to speak with a representative
- Go to **healthscopebenefits.com**, then log in to your member portal and select **Other medical insurance**
- Complete this form and **mail** to **HealthSCOPE Benefits, P.O. Box 30962, Salt Lake City, UT 84130**
- Complete this form and **fax** to **877-293-4926**

Personal information

Member name _____ Date of birth ___/___/___
MM DD YYYY

Member ID number _____ Claim number *(if applicable)* _____

Patient name _____ Name of insured _____

Phone number ___-___-___

Relationship of insured to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Does the patient have other insurance or Medicare coverage?

☐ **Yes – other insurance:** If you check this box, continue to the **Other insurance carrier** section of this form.

☐ **Yes – Medicare:** If you check this box, continue to the **Medicare** section of this form.

☐ **No** – If you check this box, continue to the signature section of this form.

(Continued)

Other insurance carrier

Name of the subscriber for the other insurance policy _____

Name of other insurance carrier _____ Insurance carrier phone ___ - ___ - ____

Name of the employer _____

Policy number _____ Group number _____

Beginning date of coverage ___ / ___ / ____ (MM / DD / YYYY) End date of coverage *(if applicable)* ___ / ___ / ____ (MM / DD / YYYY)

Other insurance covers ◯ Self ◯ Spouse ◯ Dependent ◯ Other _____

If the patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple patients, please complete a separate form for each patient.

Name of dependent(s) _____

Relationship of other insurance member to child ◯ Parent ◯ Stepparent ◯ Legal guardian ◯ Other _____

Child resides with ◯ Parent ◯ Stepparent ◯ Legal guardian ◯ Other _____

Person(s) with legal custody ◯ Parent ◯ Stepparent ◯ Legal guardian ◯ Other _____

Is there a court decree that has assigned primary responsibility for health care coverage? ◯ Yes ◯ No

Relationship of party with decreed responsibility ◯ Parent ◯ Stepparent ◯ Legal guardian ◯ Other _____

Name of responsible party _____

Mother's name _____ Date of birth ___ / ___ / ____ (MM / DD / YYYY)

Father's name _____ Date of birth ___ / ___ / ____ (MM / DD / YYYY)

Medicare

Name of individual covered by Medicare _____ Medicare ID number _____

Date of retirement *(if applicable)* ___ / ___ / ____ (MM / DD / YYYY) Medicare **Part A** effective date *(if applicable)* ___ / ___ / ____ (MM / DD / YYYY)

Medicare **Part B** effective date *(if applicable)* ___ / ___ / ____ (MM / DD / YYYY)

Medicare **Part D** prescription coverage effective date *(if applicable)* ___ / ___ / ____ (MM / DD / YYYY)

Entitlement reason ◯ Age ◯ Disability Date disability began ___ / ___ / ____ (MM / DD / YYYY)

◯ End stage renal disease First date of dialysis ___ / ___ / ____ (MM / DD / YYYY) Kidney transplant date ___ / ___ / ____ (MM / DD / YYYY)

Signature

Print employee name _____ Employee signature _____

Date ___ / ___ / ___ (MM / DD / YY)