

Post Office Box 98029
Baton Rouge, Louisiana 70898-9029
Customer Service: 1-800-495-2583 **Fax:** 1-225-298-2972
Date Printed:

OTHER COVERAGE QUESTIONNAIRE

IMPORTANT DOCUMENT

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc Policy Information

Policyholder Name _____
Address _____
City _____ State _____ Zip _____

It is important that you complete and return this questionnaire. This information is required when you are covered by more than one medical insurance provider or government plan such as Medicare. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Failure to return this questionnaire will cause a delay in processing. Thank you.

Group Number: _____ **Member Number:** _____

SECTION A – IF YOU DO NOT HAVE OTHER GROUP INSURANCE COVERAGE ONLY COMPLETE SECTION A

Are you or any dependent (spouse or children) covered by another medical, dental, Medicare insurance policy? This includes Blue Cross and Blue Shield coverage from another state.

No Other Insurance for Policyholder, Spouse, and/or Children **If no, please sign section A, date, and return this questionnaire, after checking the box indicating “No other insurance”.**

INSURED’S SIGNATURE _____ DATE _____
X

THE SECTIONS BELOW ARE FOR MEMBERS WITH OTHER INSURANCE COVERAGE INFORMATION ONLY

Yes Other Group Health Insurance Coverage If yes, please complete all the fields below that pertain to the member(s) with coverage.

- For Medicare coverage only, please complete section B and **sign on the back**.
- For other health insurance plans please complete section C and **sign on the back**.
- For other health insurance plans and Medicare, complete sections B and C and **sign on the back**.

SECTION B – MEDICARE INFORMATION

Do you and/or dependent (s) (spouse or children) have Medicare? Yes No

Name of Medicare Insured _____ Date of Birth ____/____/____

Name of *Policyholder's* Employer _____

Employment Status **Actively working** **Inactive**

Retired Retirement date: ____/____/____ **On COBRA Effective Date** ____/____/____

Medicare Number, including alpha character(s): _____

Reasons for Medicare Age Disability End Stage Renal Disease (ESRD)

Part A Medicare - Hospital <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ____/____/____	Part B Medicare - Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ____/____/____	Part C Medicare Advantage Plan <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ____/____/____
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Medicare Part D - Pharmacy Yes No Effective Date ____/____/____

If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card

RX Member ID Number	RX Bin Indicator	RX Group Number	RX PCN Number	Phone
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Name of Medicare Insured _____ Date of Birth ____/____/____

Name of *Policyholder's* Employer _____

Employment Status **Actively working** **Inactive**

Retired Retirement date: ____/____/____ **On COBRA Effective Date** ____/____/____

<See Other Side>

Reasons for Medicare	<input type="checkbox"/> Age	<input type="checkbox"/> Disability	<input type="checkbox"/> End Stage Renal Disease (ESRD)	
Part A Medicare - Hospital <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ___/___/___	Part B Medicare - Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ___/___/___		Part C Medicare Advantage Plan <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ___/___/___	
Medicare Part D - Pharmacy <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date ___/___/___				
If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card				
RX Member ID Number	RX Bin Indicator	RX Group Number	RX PCN Number	Phone

SECTION C - OTHER GROUP INSURANCE COVERAGE INFORMATION

Mark those that apply: What type of policy is this?	<input type="checkbox"/> Medical Insurance	<input type="checkbox"/> Dental Insurance	<input type="checkbox"/> Student Policy		
Other Insurance Policyholder's Name	Policyholder's DOB	Phone			
NAME(S) OF DEPENDENTS (Spouse or Children) ON POLICY					
Name	Relationship	DOB	SEX	Effective Date	Termination Date
Insurance Carrier's Name					
Insurance Carrier's Street Address				Policy ID Number	
City			State	Zip	Phone
Original Effective Date of Other Insurance ___/___/___			If Cancelled, Cancellation Date ___/___/___		
Name of Policyholder's Employer				Phone	
Employment Status	<input type="checkbox"/> Actively working for the group		<input type="checkbox"/> Inactive		
	<input type="checkbox"/> Retired Retirement Date ___/___/___		<input type="checkbox"/> On COBRA Effective Date ___/___/___		

SECTION D - COURT ORDER INFORMATION (If this does not apply, skip to section E)

Is there a legally binding agreement stating that the parent without majority custody has primary responsibility for the child's health care expenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is yes, please provide the effective date of the agreement? ___/___/___		
List the name(s) of the dependent(s) this applies. <i>Note: Documentation of the court order may be requested.</i>		
If yes, who is listed to maintain health coverage?		
What is the relation to the children?	Who has custody of the child or children more than 50% of the time?	

SECTION E

I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
INSURED'S SIGNATURE X	DATE