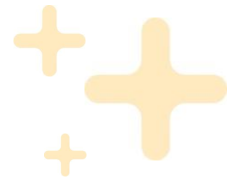
**PROVIDENCE** Health Plan



# Providence Other Medical Insurance Coverage Questionnaire

Thank you for your membership with Providence Health Plan. Please complete the questionnaire below to submit your Other Medical Insurance Information.

**While covered under a Providence Health Plan, have you or any other family member(s) also had coverage under another medical insurance?**

☐ Yes ☐ No

### If no, please sign, date, and return this form:

Signature: ________________________________________

Date: ____________

### If yes, please complete the following applicable sections.

**Please complete the following information for any other health insurance policy:**

Name of person carrying other policy: _____________________________________

Birthdate: ____________

Members covered: ___________________________________________________

Insurance company name: ____________________________________________

Insurance company phone: ___________________________

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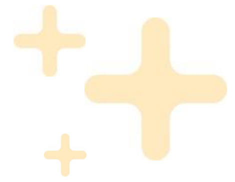

Member ID number ______________________________________

Group number: __________________

Coverage start date: _______________ Coverage end date: _______________

Name of employer providing coverage: ________________________________

Coverage includes: ☐ Medical ☐ Vision ☐ Prescription

Type of coverage: ☐ Group plan ☐ Individual plan ☐ Retirement plan

☐ COBRA ☐ VA benefits ☐ Other: ______________

## Dependent Children

Has the custody of any dependent(s) covered under this plan been determined by a court or divorce decree? ☐ Yes ☐ No

**If yes, please provide a copy of court order or divorce decree, which names the "Petitioner" and "Respondent."**

## Medicare

Are you, your spouse, or your dependent(s) eligible for Medicare? ☐ Yes ☐ No

**If entitled to Medicare but have not enrolled, please provide the reason why:**

____________________________________________________________

____________________________________________________________

____________________________________________________________

Is Medicare due to:

Age ☐ Yes ☐ No

Disability ☐ Yes ☐ No

ESRD ☐ Yes ☐ No Date of dialysis: _______________

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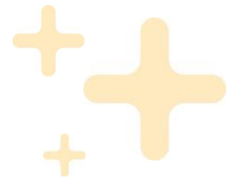


Your Medicare ID number: ______________________

**Part A:** ☐ Yes ☐ No Effective date: ___________________

**Part B:** ☐ Yes ☐ No Effective date: ___________________

**Part D:** ☐ Yes ☐ No Effective date: ___________________

Spouse's Medicare ID number: ______________________

**Part A:** ☐ Yes ☐ No Effective date: ___________________

**Part B:** ☐ Yes ☐ No Effective date: ___________________

**Part D:** ☐ Yes ☐ No Effective date: ___________________

Dependent's Medicare ID number: ______________________

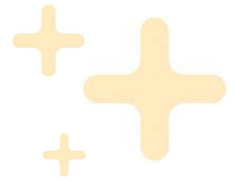
**Part A:** ☐ Yes ☐ No Effective date: ___________________

**Part B:** ☐ Yes ☐ No Effective date: ___________________

**Part D:** ☐ Yes ☐ No Effective date: ___________________

**I certify that the above statements are true and correct to the best of my knowledge.**

**Signature:** _________________________________________ **Date:** _______________



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## Return completed form:

**Online:** visit our secure website https://myprovidence.healthtrioconnect.com

+ Navigate to Benefits & Coverage
+ Select Additional Insurance Form

**Email:** send to phpcobletter@providence.org with your Member ID# in the subject line

**Mail:** 3601 SW Murray Blvd. Beaverton, OR 97005 Attn: OFT

**Fax:** 503-574-8621