

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: _____

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: _____

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:** _____

Return completed form:

Online: visit our secure website <http://www.myprovidence.com>

- Navigate to My Health Plan
- Select Additional Insurance Form

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

Mail: PO Box 4327, Portland, OR 97208 Attn: OFT

Fax: 503-574-8621