415 W. 17th Street
Suite 140
Cheyenne, WY 82001

Other Coverage Questionnaire

Name: _____

ID Number: _____

In order to process your claims promptly and accurately it is important that the following information be provided to our office. Please complete this form and return it to the address listed above. If you do not have any other health insurance, mark the appropriate box below and return the form to us.

I do not have any other insurance. ☐

I have other insurance. ☐

Please complete the following:

Name and Address of Other Insurance Company:

_____

_____

_____

Phone Number: _____

Coverage Type: ☐ Health ☐ Dental ☐ Other Please Describe: _____

Policy Type: ☐ Group Coverage ☐ Non-Group Coverage

Policy Holder Name: _____
Social Security Number: _____
Policy Number: _____
When Did Coverage Begin: _____
Does Policy Have a Coordination of Benefits Provision? ☐ Yes ☐ No
Names of Family Members Covered Under This Policy:

_____ _____
_____ _____
_____ _____
_____ _____

Member Signature: _____

Thank you in advance for your cooperation. If you have any questions, please contact our office by calling 1.307.634.5566.

7/2020