P O Box 2266
Cheyenne, WY 82003

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 Member Services Department by calling 1.800.442.2376.