TPSC BENEFITS

OTHER COVERAGE QUESTIONNAIRE

ADMINISTRATORS FOR EMPLOYEE BENEFITS PLANS

Mailing Address: P.O. Box 1894 • Tacoma, WA 98401
Physical Address: 1101 Pacific Ave. Suite 300, Tacoma, WA 98402

Phone: 253.564.5611 ext. 210 • **Fax:** 253.564.5881 • **Toll Free:** 800.426.9786 ext. 210

PATIENT PROFILE

Insured Name:	Employer Name:
Birth Date:	Social Security #:
Home Phone #:	Work Phone #:

This request for another coverage update will be sent once a year to ensure that your claims are being processed properly. When you or your dependents have other health coverage, the information requested below will enable us to process payment of your claim(s) and determine the primary payor as outlined by your health care benefit plan.

Within the last 12 months, have you or any member of your family been covered by another healthcare plan, or any government program including a medicare plan?

☐ No — No further information is required. Please sign, date, and return this form in the enclosed envelope.

☐ Yes — Please complete the following information.

OTHER INSURANCE INFORMATION

Name of Insurance Company:		
Phone #:	Effective Date of Coverage:	Date Coverage Terminated:
Name of Policyholder:		Birth Date:
Relationship to ***Our*** Subscriber:		
Policy ID #: (*Subscriber or member #)*		Group #:

Type of coverage:

☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

Who is covered under this policy?

☐ Policyholder/Subscriber ☐ Spouse ☐ Dependent Children

If spouse and/or dependent children are checked above, please complete below.

Name of Spouse:	Birth Date:	Social Security #:
Name of Child:	Birth Date:	Social Security #:
Name of Child:	Birth Date:	Social Security #:

Subscriber Signature _____ Date _____

BY SIGNING THIS FORM I AM CERTIFYING THAT I HAVE READ AND COMPLETED BOTH SIDES OF THIS FORM.

OTHER COVERAGE QUESTIONNAIRE

If parents are divorced or legally separated, the following information is needed to determine which coverage will process claims first for dependent children. **PLEASE ATTACH LEGAL DOCUMENTATION REGARDING CUSTODY AND FINANCIAL RESPONSIBILITY FROM THE DIVORCE DECREE.**

Name of Parent With Custody:	Birth Date:
If divorced, does the decree state which parent is financially responsible for health coverage? ☐ Yes ☐ No	
If "yes", Name of Parent:	
Please list all other coverage information below: *(i.e., telephone number, name of policyholder, id number, group number, etc.)*	