Kansas City

2301 Main Street Kansas City, MO 64108 • (816) 395-2222 • BlueKC.com

Other Medical Coverage Information

This form is submitted to inform us of all insurance coverage available to you. If you have other insurance in addition to your Blue Cross and Blue Shield coverage, we will need your other insurance information. By coordinating benefits with all insurance carriers, the insured receives the maximum benefits available. Please return this form either via mail to the address on the back of the Member ID card or fax to 816-817-2160.

Section A – Instructions for YES response. Answer all three questions.

1. Do you or your family members have **Medicare** insurance as other coverage?

   ☐ NO ☐ YES (If yes, complete **Section B**)

2. Do you or your family members have other medical insurance coverage (including any otherBlue Cross and Blue Shield plan)?

   ☐ NO ☐ YES (If yes, complete **Section C**)

3. Are any of your family members currently subject to a divorce decree or court order?

   ☐ NO ☐ YES (If yes, complete **Section D**)

Please proceed to **Section B** and the next page to complete **Sections C and/or D** if applicable.

Name of Facility/Provider		Patient Name	

Section B – Medicare Information

Beneficiary's Name:_____Date of Birth:___/__/____Medicare ID #:_____

Effective Date: Part A:_____/____/_____Part B:_____/____/_____Part D:_____/____/_____

If the beneficiary is retired, please indicate retirement date:_____/____/_____

Entitlement reason: ___ Age, ___ Disability, ___End stage renal disease

If coverage due to End-Stage Renal Disease; Please provide the date of first dialysis treatment:

_____ Home

_____ Facility/Dialysis Center

_____ Date of transplant if applicable

Section C – Other Medical Insurance Coverage Information

(This applies to Medical Coverage only. Do not provide us with information regarding your Dental Coverage) Other Insurance Carrier

Name: _____

Address:_____Phone Number: ( )_____-_____

Policy #:_____Effective / Termination Date:____/___/____ ___/____/____

Policyholder's Name:_____DOB:____/___/___SSN: _____

Patient relationship to subscriber:_____

Please circle all that apply

Coverage Type: **Medical / Drug** Policy Type: **Active / Retiree / Cobra**

List other members covered by this policy:

Name:_____SSN:_____DOB:____/____/_____

Name:_____SSN:_____DOB:_____/____/_____

Name:_____SSN:_____DOB:_____/____/_____

If the patient is your child, please provide the following:

Father's Name:_____ Mother's Name:_____

DOB:_____/_____/_____ DOB:_____/_____/_____

If you need more space, please attach another sheet.

Section D – Divorce Decree or Court Order Information

If divorce decree states that a parent **must** provide medical insurance for the dependent, what is the name and date of birth of the parent responsible?

Name of Dependent	DOB	Responsible Parent	DOB
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

Please send a copy of the divorce decree or court order indicating responsibility.

To ensure we have the correct number in the event we need to contact you, please provide a daytime phone number where you can be reached between 8:00 a.m. and 4:30 p.m., Monday through Friday.

I CERTIFY THAT THE INFORMATION GIVEN IS COMPLETE AND TRUE.

Print Name:_____Daytime phone: ( )_____-_____

Member Signature:_____Date: _____