FirstCare HEALTH PLANS

Other Insurance Survey

Please take a moment to complete and return this questionnaire regarding other health coverage information for you and your dependents. We ask that you update, verify or provide other medical coverage information at least once a year. You can also update your information on our member Self-Service Portal at **my.firstcare.com**.

Please list and provide information for ***all*** members covered under your policy.

Other Health Care Coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Name: ______________________________
ID#: ______________________________

- ❑ Medicare—*complete questionnaire on back*
- ❑ Medicaid—*complete questionnaire on back*
- ❑ Other—*complete questionnaire on back*
- ❑ No other coverage

Please return this completed form to:

FirstCare Health Plans
P.O. Box 853935
Richardson, TX 75085-3935

If you have any questions, or require additional information, please contact us at the phone number listed on your FirstCare ID card.

Other Health Insurance: If you or your dependents are covered by any other policy, in addition to the policy with us, please provide the other coverage information below. If the other coverage is provided by Medicare, please leave this section blank and provide Medicare coverage information under the Medicare section. Please duplicate this form if necessary to include additional dependent information.

Policy No. 1: This coverage is applicable to ❑ Self (contract holder) ❑ Spouse ❑ Dependent (list dependents covered in box below)

Other Insurance Information:

Name: _____

Telephone Number: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Termination Date: _____

Is it a retiree policy? ❑ Yes ❑ No

Is this court-ordered coverage? ❑ Yes ❑ No

Coverage type *(Check all that apply)*:
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental

Other Coverage Policy Holder Information:

Name: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

List Dependents covered by this policy: _____

_____

Policy No. 2: This coverage is applicable to ❑ Self (contract holder) ❑ Spouse ❑ Dependent (list dependents covered in box below)

Other Insurance Information:

Name: _____

Telephone Number: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Termination Date: _____

Is it a retiree policy? ❑ Yes ❑ No

Is this court-ordered coverage? ❑ Yes ❑ No

Coverage type *(Check all that apply)*:
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental

Other Coverage Policy Holder Information:

Name: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

List Dependents covered by this policy: _____

_____

Medicare Coverage: Please complete this section if you or your spouse are covered by Medicare.

Policy No. 1: This coverage is applicable to ❑ Self (contract holder) ❑ Spouse ❑ Dependent: (name) _____

Medicare Policy Number: _____

Eligibility due to: ❑ 65 years of age or older ❑ Disability
❑ End Stage Renal Disease

Do you have Part A? ❑ Yes ❑ No Effective Date: _____

Do you have Part B? ❑ Yes ❑ No Effective Date: _____

Do you have Part D? ❑ Yes ❑ No Effective Date: _____

Current working status: _____

If employed—Company Name: _____
If retired—Retirement Date: _____

Are you working with another company?

❑ Yes – Employer Name: _____ ❑ No

Policy No. 2: This coverage is applicable to ❑ Self (contract holder) ❑ Spouse ❑ Dependent: (name) _____

Medicare Policy Number: _____

Eligibility due to: ❑ 65 years of age or older ❑ Disability
❑ End Stage Renal Disease

Do you have Part A? ❑ Yes ❑ No Effective Date: _____

Do you have Part B? ❑ Yes ❑ No Effective Date: _____

Do you have Part D? ❑ Yes ❑ No Effective Date: _____

Current working status: _____

If employed—Company Name: _____
If retired—Retirement Date: _____

Are you working with another company?

❑ Yes – Employer Name: _____ ❑ No

Medicaid Coverage: Please complete this section if you or your spouse and/or dependent(s) are covered by Medicaid.

Subscriber Name:	Medicaid ID: _____ Effective Date: _____	Dependent Name:	Medicaid ID: _____ Effective Date: _____
Dependent Name:	Medicaid ID: _____ Effective Date: _____	Dependent Name:	Medicaid ID: _____ Effective Date: _____
Dependent Name:	Medicaid ID: _____ Effective Date: _____	Dependent Name:	Medicaid ID: _____ Effective Date: _____
Dependent Name:	Medicaid ID: _____ Effective Date: _____	Dependent Name:	Medicaid ID: _____ Effective Date: _____