Other Insurance Coverage Information

Complete and return to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

Meritain Health Welcomes You! To help us properly handle any existing or future claims, please tell us about any other healthcare coverage you and/or your dependents may have. Examples include another group plan, an individual policy, COBRA, Medicare, Medicaid, state programs, Social Security benefits due to a disability, or medical expenses covered by another person due to a court order/decree. **If we do not receive this information, it may delay the processing and payment of your claims.**

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER COVERAGE IN EFFECT AT THIS TIME?
❑ YES ❑ NO

PLEASE PRINT:	
EMPLOYEE NAME	EMPLOYEE DOB
NAME OF COMPANY (YOUR EMPLOYER):	GROUP NUMBER
MEMBER ID NUMBER	

COMPANY / PROGRAM NUMBER 1	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH (POLICY HOLDER)	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN	RELATION TO POLICY HOLDER
WHAT TYPE OF COVERAGE IS THIS? ❑ MEDICAL ❑ DENTAL ❑ VISION	

COMPANY / PROGRAM NUMBER 2	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN	RELATION TO POLICY HOLDER
WHAT TYPE OF COVERAGE IS THIS? ❑ MEDICAL ❑ DENTAL ❑ VISION	

MEDICARE		
NAME OF PERSON COVERED BY MEDICARE	MEDICARE ID NUMBER:	
REASON FOR MEDICARE ELIGIBILITY: ❑ OVER AGE 65 ❑ TOTAL DISABILITY ❑ END-STAGE RENAL DISEASE _____ (provide dialysis date)		
PART A EFFECTIVE DATE(S)	PART B EFFECTIVE DATE(S)	PART D EFFECTIVE DATE(S)

COURT ORDER OR DECREE	
COVERED INDIVIDUALS	EFFECTIVE DATE
NAME OF PARENT(S) WITH LEGAL CUSTODY OF CHILDREN	ADDRESS OF PARENT(S) WITH LEGAL CUSTODY
FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DENIAL OF CLAIMS SUBMITTED BY YOU AND YOUR FAMILY MEMBERS.	