BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

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Date Printed:

OTHER COVERAGE QUESTIONNAIRE

IMPORTANT DOCUMENT

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc Policy Information
Policyholder Name
Address
City State Zip

It is important that you complete and return this questionnaire. This information is required when you are covered by more than one medical insurance provider or government plan such as Medicare. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Failure to return this questionnaire will cause a delay in processing. **PLEASE GO TO WWW.BCBSLA.COM AND THEN SELECT LOGIN AT THE TOP RIGHT OF THE WEB PAGE.** Thank you.

Group Number: _____ **Member Number:** _____

SECTION A – IF YOU DO NOT HAVE OTHER GROUP INSURANCE COVERAGE ONLY COMPLETE SECTION A	
Are you or any dependent (spouse or children) covered by another medical, dental, Medicare insurance policy? This includes Blue Cross and Blue Shield coverage from another state.	
☐ **No Other Insurance for Policyholder, Spouse, and/or Children**	**If no, please sign section A, date, and return this questionnaire, after checking the box indicating "No other insurance".**
INSURED'S SIGNATURE **X**	**DATE**

THE SECTIONS BELOW ARE FOR MEMBERS WITH OTHER INSURANCE COVERAGE INFORMATION ONLY	
☐ **Yes** **Other Group Health Insurance Coverage**	If yes, please complete all the fields below that pertain to the member(s) with coverage. • For Medicare coverage only, please complete section B and ***sign on the back.*** • For other health insurance plans please complete section C and ***sign on the back.*** • For other health insurance plans and Medicare, complete sections B and C and ***sign on the back.***

SECTION B – MEDICARE INFORMATION				
Do you and/or dependent (s) (spouse or children) have Medicare?	☐ Yes ☐ No			
Name of Medicare Insured			**Date of Birth** ___/___/_____	
Name of *Policyholder*'s Employer				
Employment Status	☐ ***Actively working***		☐ ***Inactive***	
	☐ ***Retired Retirement date:*** __/__/____		☐ ***On COBRA Effective Date*** __/__/____	
Medicare Number, including alpha character(s):				
Reasons for Medicare	☐ Age	☐ Disability	☐ End Stage Renal Disease (ESRD)	
Part A Medicare - Hospital ☐ Yes ☐ No **Effective Date** __/____	**Part B Medicare - Medical** ☐ Yes ☐ No **Effective Date** __/____		**Part C Medicare Advantage Plan** ☐ Yes ☐ No **Effective Date** ___/____	
Medicare Part D - Pharmacy ☐ Yes ☐ No **Effective Date** ___/___/____				
If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card				
RX Member ID Number	**RX Bin Indicator**	**RX Group Number**	**RX PCN Number**	**Phone**
Name of Medicare Insured			**Date of Birth** ___/___/_____	
Name of *Policyholder*'s Employer				
Employment Status	☐ ***Actively working***		☐ ***Inactive***	
	☐ ***Retired Retirement date:*** __/__/____		☐ ***On COBRA Effective Date*** __/__/____	

<See Other Side>

Reasons for Medicare	☐ Age	☐ Disability	☐ End Stage Renal Disease (ESRD)

Part A Medicare - Hospital	Part B Medicare - Medical	Part C Medicare Advantage Plan
☐ Yes ☐ No **Effective Date** __/____	☐ Yes ☐ No **Effective Date** __/____	☐ Yes ☐ No **Effective Date** __/____

Medicare Part D - Pharmacy ☐ Yes ☐ No **Effective Date** ___/___/____

If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card

RX Member ID Number	RX Bin Indicator	RX Group Number	RX PCN Number	Phone

SECTION C - OTHER GROUP INSURANCE COVERAGE INFORMATION

Mark those that apply: What type of policy is this?	☐ Medical Insurance	☐ Dental Insurance	☐ Student Policy

Other Insurance Policyholder's Name	*Policyholder's DOB*	*Phone*

NAME(S) OF DEPENDENTS(Spouse or Children) ON POLICY

Name	*Relationship*	*DOB*	*SEX*	*Effective Date*	*Termination Date*

Insurance Carrier's Name

Insurance Carrier's Street Address			*Policy ID Number*
City	***State***	***Zip***	***Phone***

Original Effective Date of Other Insurance ___/___/_____	*If Cancelled, Cancellation Date* ___/___/_____

Name of Policyholder's Employer	*Phone*

Employment Status	☐ *Actively working for the group*	☐ *Inactive*
	☐ *Retired* *Retirement Date* __/__/____	☐ *On COBRA Effective Date* __/__/____

SECTION D - COURT ORDER INFORMATION (If this does not apply, skip to section E)

Is there a legally binding agreement stating that the parent **without** majority custody has primary responsibility for the child's health care expenses? ☐ **Yes** ☐ **No**

Is yes, please provide the effective date of the agreement? __/__/____

List the name(s) of the dependent(s) this applies. ***Note: Documentation of the court order may be requested.***

If yes, who is listed to maintain health coverage?

What is the relation to the children?	Who has custody of the child or children more than 50% of the time?

SECTION E

I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

INSURED'S SIGNATURE	DATE
X	