

CMSP OTHER HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. **Attach a copy of your insurance policy, membership card or any other documents to help complete this questionnaire.** PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. FAILURE TO REPORT OTHER HEALTH INSURANCE MAY CAUSE OVERPAYMENT OR TERMINATION OF YOUR CMSP ELIGIBILITY.

Case number:	CIN:
--------------	------

Section I: Please list the name of the person covered by other health insurance

Name (first, middle, last)	Date of Birth	Social Security Number	Sex

Section II: Health Insurance Information (Insurance 1)

Health Insurance Information (Insurance 2)

<p>1. What is the name and address of your health insurance company? Include street number, city, state and ZIP. Do not use abbreviations.</p> <p>Company Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p>	<p>1. What is the name and address of your health insurance company? Include street number, city, state and ZIP. Do not use abbreviations.</p> <p>Company Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p>
<p>2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. What is the full name, address, phone number, and Insurance Identification Number of the individual, employee, union member, or person to whom the insurance policy was issued? Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insured Name: _____</p> <p>Insurance ID Number: _____</p> <p>Address: _____</p> <p>Telephone number: (_____) _____</p> <p>City, State, ZIP: _____</p>	<p>3. What is the full name, address, phone number, and Insurance Identification Number of the individual, employee, union member, or person to whom the insurance policy was issued? Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insured Name: _____</p> <p>Insurance ID Number: _____</p> <p>Address: _____</p> <p>Telephone number: (_____) _____</p> <p>City, State, ZIP: _____</p>
<p>4. What is the policy number?</p> <p>5. What are the dates of your policy? Beginning date: _____ Ending date(if applicable): _____</p>	<p>4. What is the policy number?</p> <p>5. What are the dates of your policy? Beginning date: _____ Ending date(if applicable): _____</p>
<p>6. Give name, address, and telephone number of union, employer, group, organization, or school that your insurance policy is through.</p> <p>Group Name: _____</p> <p>Local or group number: _____</p> <p>Address: _____</p> <p>Telephone number: (_____) _____</p> <p>City, State, ZIP: _____</p>	<p>6. Give name, address, and telephone number of union, employer, group, organization, or school that your insurance policy is through.</p> <p>Group Name: _____</p> <p>Local or group number: _____</p> <p>Address: _____</p> <p>Telephone number: (_____) _____</p> <p>City, State, ZIP: _____</p>
<p>7. Does your health insurance provide or pay for: (Check all that apply)</p> <p><input type="checkbox"/> Hospital outpatient (i.e. lab work/physical therapy)</p> <p><input type="checkbox"/> Prescription drugs <input type="checkbox"/> Long-term care/nursing home</p> <p><input type="checkbox"/> Hospital stays <input type="checkbox"/> Doctor visits <input type="checkbox"/> Dental care <input type="checkbox"/> Vision care</p> <p><input type="checkbox"/> Only specific illness (i.e. cancer)</p> <p>◆ Type of illness: _____</p>	<p>7. Does your health insurance provide or pay for: (Check all that apply)</p> <p><input type="checkbox"/> Hospital outpatient (i.e. lab work/physical therapy)</p> <p><input type="checkbox"/> Prescription drugs <input type="checkbox"/> Long-term care/nursing home</p> <p><input type="checkbox"/> Hospital stays <input type="checkbox"/> Doctor visits <input type="checkbox"/> Dental care <input type="checkbox"/> Vision care</p> <p><input type="checkbox"/> Only specific illness (i.e. cancer)</p> <p>◆ Type of illness: _____</p>

Section III: Signature

Signature of applicant:	Home telephone number:	Date:
Signature of person helping the applicant:	Home telephone number:	Date:

The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the CMSP. This information will be used by the County Department to establish initial and ongoing CMSP eligibility; by the CMSP's fiscal intermediary for claims processing purposes; by the CMSP Governing Board, Anthem Blue Cross, MedImpact, Doral Dental and VSP for benefit administration and claims payment, health insurance identifications and overpayment recovery actions.