Medicare Advantage Plans
P.O. Box 1678 | Oklahoma City, OK 73101-1678

Request for Other Insurance Coverage Information

Your Medicare Advantage plan contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the Customer Service number found on the back of your identification card. We appreciate your prompt reply.

OTHER INSURANCE: (PLEASE PRINT IN BLUE OR BLACK INK)

Are you covered by another medical or prescription insurance policy?

NO ☐	IF NO, PLEASE MAKE ANY REVISIONS NECESSARY TO THE INFORMATION BELOW, SIGN, DATE AND RETURN THIS QUESTIONNAIRE TO US, INDICATING **"NO OTHER INSURANCE"**	**YES** ☐	IF YES, PLEASE MAKE ANY REVISIONS TO AND/OR COMPLETE ALL THE NECESSARY INFORMATION BELOW, INDICATING **"OTHER INSURANCE"**

Member Name: ____

Member ID Number: ____

OTHER INSURANCE CARRIER:

Type of Insurance (Check all that apply): ☐ Medical ☐ Prescription

Type of Policy (Check all that apply): ☐ Employer Group ☐ Individual ☐ Supplemental ☐ Veteran

Name of the Subscriber for the Other Insurance Policy: ________________________________

Working Status of the Subscriber (Check One): ☐ Actively Working ☐ Retired ☐ COBRA

Name of the Employer: ____

Name of Other Insurance Carrier: ____

Insurance Carrier Phone Number: ____

Policy Number: ______________________ **Group Number:** _________________________

Beginning Date of Coverage: ____________ **End Date of Coverage (if applicable):** __________

____ ______________________

Signature of the Person Completing this Form **Date**