BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Post Office Box 98029
Baton Rouge, Louisiana 70898-9029

OTHER COVERAGE QUESTIONNAIRE
RESPONSE REQUIRED

Customer Service: 1-888-223-2583 Fax: 1-225-298-2972

This information is required to complete the processing of any claims submitted. Failure to return this questionnaire will cause a delay in processing. Please fill out this questionnaire and return it to us within ten (10) days. A return envelope has been provided, as well as toll-free customer service phone numbers and facsimile numbers. Thank you for your prompt response.

Name _____

Address _____

City _____ State _____ Zip _____

Member Number _____

Please check all that apply to you as the policy holder:

☐ MALE	☐ FEMALE
☐ EMPLOYED	☐ RETIRED
If retired, please provide a retired date ____/____/____	
☐ MARRIED	☐ SINGLE/WIDOWED
☐ DIVORCED/LEGALLY SEPARATED	

In addition to your Blue Cross and Blue Shield Plan of Louisiana coverage, are/were you, your spouse, or dependent children covered by Medicare or another group health insurance plan (including any other Blue Cross and Blue Shield coverage?)

☐ **NO: Signature** _____ ☐ **YES: Please provide the following applicable information.**

Yes: Medicare Coverage – Please Complete

Are you or your dependent(s) enrolled in any of the following Medicare Programs? **If yes**, please check the applicable answers and provide the effective dates.

SELF

Name of Beneficiary (Insured): _____ Medicare ID Number: _____

☐ Male ☐ Female Date of Birth: ____/____/____

Reasons for Medicare: ☐ Age ☐ Disability ☐ Disability/ESRD ☐ ESRD First Dialysis ____/____/____

Part A – Hospital: ☐ No ☐ Yes ____/____/____

Part B – Medical: ☐ No ☐ Yes ____/____/____

Part C – Medicare Advantage Plan: ☐ No ☐ Yes ____/____/____

Part D – Pharmacy: ☐ No ☐ Yes ____/____/____ **If yes for Part D**, please provide the following information from your Prescription Drug Plan Identification Card:

Rx Member ID Number _____ Rx Group Number _____

Rx BIN Number _____ Rx PCN Number _____ Phone Number _____

DEPENDENT ☐ Spouse ☐ Child ☐ Other _____

Name of Beneficiary (Insured): _____ Medicare ID Number: _____

☐ Male ☐ Female Date of Birth: ____/____/____

Reasons for Medicare: ☐ Age ☐ Disability ☐ Disability/ESRD ☐ ESRD First Dialysis ____/____/____

Part A – Hospital: ☐ No ☐ Yes ____/____/____

Part B – Medical: ☐ No ☐ Yes ____/____/____

Part C – Medicare Advantage Plan: ☐ No ☐ Yes ____/____/____

Part D – Pharmacy: ☐ No ☐ Yes ____/____/____ **If yes for Part D**, please provide the following information from your Prescription Drug Plan Identification Card:

Rx Member ID Number _____ Rx Group Number _____

Rx BIN Number _____ Rx PCN Number _____ Phone Number _____

Yes: Other Group Health Insurance – Please Complete

Name of policyholder of other insurance: Last _____ First _____ M.I. _____ ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____ Relationship to You: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Name of other insurance company: _____

Address of other insurance company: _____

Phone Number of other insurance company: _____

Policy or Group Number: _____ Effective Date: ____/____/____

Name of group or employer issuing this coverage: _____

Phone number of group or employer issuing this coverage: _____ Termination date if applicable: ____/____/____

Employment status of covered person: ☐ Active ☐ Retired on: ____/____/____

Please check all types of coverage that apply:
☐ Hospitalization ☐ Medical/Surgical ☐ Prescription Drug ☐ Major Medical
☐ Mental Conditions/Substance Abuse ☐ Dental ☐ Vision

This policy covers: ☐ Policyholder Only ☐ Policyholder and Spouse ☐ Policyholder and Children ☐ Family

If the above policy covers dependent children, please complete the following:
☐ Yes ☐ No Parents are married
☐ Yes ☐ No Parents are divorced/legally separated
☐ Yes ☐ No Divorced/legally separated parents have joint custody
If no, who is the legal parent with majority custody? ☐ Mother ☐ Father ☐ Other _____

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

If so, please provide the effective date of the agreement: _____

Name of responsible parent: _____

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

Subscriber's Signature: _____ Date: _____

Spouse's Name: _____ Daytime Telephone Number: _____