OTHER COVERAGE QUESTIONAIRE

Do you or any of your dependents have health insurance through Medicare or another carrier?

Maybe your spouse and you both have coverage through your separate employers, or perhaps you just became eligible for Medicare. If you find yourself covered by another insurance company or plan, we need to know in order to ensure we are managing your benefits correctly and you are getting the full benefit of each plan.

What is the difference between primary and secondary coverage?

Primary Coverage is the plan that is responsible for paying your medical claims first, before any other insurance plan or coverage.

Secondary Coverage provides additional coverage for your eligible medical expenses after your primary plan has first paid it's share.

Please note, you do not choose which coverage is primary and which is secondary, those rules are set by laws and regulations as well as any specific plan guidelines.

Please use this form to let us know of any other coverage you or your covered dependents may have, including Medicare.

- Complete all fields of this form.
- Keep a copy of the completed form for your records.
- Send the completed form to us directly at the address or Fax number shown below.
- Should this information change at any time, please complete a new form and let us know of the change so that we can process your eligible claims correctly.
- This information will be requested from you on an annual basis, or according to the timeframes required by your health plan

What happens next?

After we receive your signed and completed questionnaire we will update our system with this information. Should you have any claims that were previously denied for this information, those claims will automatically be processed and you will receive a new explanation of benefits (EOB). The EOB explains the charges applied to your deductible (amount you pay for covered services before your plan begins to pay) and any charges you may owe the provider, as well as any amounts already paid by your primary coverage if applicable. Please keep your EOB on file in case you need it in the future. You can also access your claim information at our website www.vch-compass.com.

EMPLOYEE/SUBSCRIBER INFORMATION

Employee Name (Last, First, Middle Initial)	Member ID / Group No.
Employee Home Address (Street, City, State, Zip Code)	
Employee Date of Birth	Employee Phone #

OTHER COVERAGE INFORMATION

Do you or any of your covered dependents have other existing health coverage (other than listed above)?

☐ No -Please sign and date the bottom of this form and return to Compass Health Administrators

☐ Yes -Please provide requested information below for each additional carrier/plan and list every covered member under that plan

Please complete the following information for you, your spouse, or any other dependents that have other health or prescription coverage in addition to the coverage identified above.

Carrier/Plan Name	Policyholder Name	DOB

Plan Type ☐Employer ☐Medicare ☐Individual ☐Retiree ☐COBRA ☐Other _____

Coverage Type (Medical, Dental, Vision)	Effective Date / /	Termination Date / /

FIRST NAME	LAST NAME	RELATIONSHIP	COVERAGE EFFECTIVE DATE	IS COVERAGE COURT ORDERED*	RESIDES IN SAME HOUSEHOLD
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No

*If Yes, please note the effective date of the agreement here:_____

Documentation may be requested.

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to criminal penalties.

Signature: _____ Date: _____

RETURN COMPLETED FORM via email, fax or mail to:

customerservice@compasshealthadministrators.com | PO Box 25190 Fresno, CA 93729 | (888) 858-6427 | Fax (559) 293-3705