636 Solarex Court ◆ P.O. Box 1169 ◆ Frederick, MD 21702-0169 ◆ (301) 694-6060 ◆ Fax: (301) 694-0501

Date: _______________

Name: ___________________________________
Address: ___________________________________
____
____

RE: Other Insurance Questionnaire
Group ID: ___________________________________
Group Name: ___________________________________
Insured ID: ___________________________________
Insured Name: ___________________________________
Patient Name: ___________________________________

Dear ______________________________:

In order to ensure prompt and accurate claims administration, it is necessary for us to periodically request the following information. Please take a moment to complete and return this questionnaire to our office.

(1) What is your current marital status?
_____Single
_____Married
_____Legally Separated
_____Widowed

(2) If married, is your spouse employed?
_____Yes
_____No
_____Not applicable

(3) Do you, your spouse or children have coverage with any other Group Health Plan such as an HMO, Blue Cross/Blue Shield, Medicare or other state or government agency, including Champus?
_____Yes
_____No (please sign and date below)

(4) If yes, please complete the following information regarding your other coverage to the best of your knowledge.
A. Name of Insurance Carrier _______________________________________
Address _______________________________________
____
Phone # _______________________________________

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B. Primary Cardholder Name ________________________________
Date of Birth ________________________________
Member#/Social Security# ________________________________

C. Effective Date of Coverage ________________________________

D. Group Name/Policy# ________________________________

(5) Who is covered under this plan? (Name and relationship to cardholder)

Thank you for your time. Please sign and date below.

Signature ________________________________ Date ________________

Claims Department