Other Insurance

Dear Independent Health Subscriber,
Please complete the information below if you or a family member have **other health insurance** (including an open **workers' compensation** and/or **motor vehicle** accident/injury). Return it as soon as possible to ensure the timely processing of your claims. Thank you.

Subscriber Name: _____ Independent Health ID #: _____

OTHER HEALTH INSURANCE

Name & Address of Other Insurance Carrier:

_____

_____

_____

Phone No.: _____

Policy Holder: _____

Policy ID #: _____

Effective Date: _____

Member(s) Covered (First and Last Name(s)):

_____

_____

_____

Coverage Includes: (Check appropriate boxes):

Medical ☐ Y ☐ N Hospital ☐ Y ☐ N

Vision ☐ Y ☐ N Prescription ☐ Y ☐ N

Dental ☐ Y ☐ N

NO-FAULT (Motor Vehicle Accident)

Family Members Involved: _____

_____

Date of Accident: _____

Medical Injuries: ☐ Y ☐ N Injury: _____

Insurance Company Name: _____

Phone No.: _____

WORKERS' COMPENSATION

Member(s) Name: _____

Date of Injury: _____

Injury/Injuries: _____

Employer's Name: _____

Employer's Phone No.: _____

Employer's Compensation Carrier/Address/Phone #:

_____

_____

WCB No.: _____ Claim No.: _____

IF NO OTHER INSURANCE ✓ HERE ☐ AND RETURN

Please complete the information below if you, your spouse, or dependent(s) have **Medicare** insurance. Return it as soon as possible to ensure the timely processing of your claims. Thank you.

Subscriber Name: _____ Independent Health ID #: _____

My Medicare Number is: _____ Medicare Effective Date: _____

A) I Have (Please check ☐)

(1) Hospital Coverage (Part A) ☐

Effective _____ / _____ / _____

(2) Medical Coverage (Part B) ☐

Effective _____ / _____ / _____

B) I Am (Please check ☐)

(1) Retired _____ (Retirement Date _____)

(2) Still Actively Employed:

Full-time ____ Part-time ____

Name of current employer

(self) _____

(spouse) _____

C) I Have (Please check ☐)

(1) Social Security (Over 65 Years Old) ☐

(2) Disability (Under 65 Years Old) ☐

(3) Renal Failure Coverage ☐

a) Date of first dialysis treatment _____ / _____ / _____

b) Date of renal kidney transplant _____ / _____ / _____

D) My Spouse is (Please check ☐)

(1) Retired ____ (Retirement Date _____)

(2) Medicare ID # _____

(3) Social Security # _____

(4) Still Actively Employed? Yes ☐ No ☐

Dependents _____

_____

*Please provide a **copy** of your and/or spouse's/dependent's Medicare card(s) for our records.*