

HealthChoice
P.O. Box 24110 Oklahoma
City, OK 73124



Date: _____
Name : _____
Address : _____
City/State/Zip: _____, _____
Member ID Number: _____
Member Name: _____
Patient Name: _____

Are you, your enrolled spouse or enrolled dependents covered under any other group insurance (other than HealthChoice) or Medicare?

YOU - () YES () NO SPOUSE - () YES () NO DEPENDENT(S) - () YES () NO

If you answered NO to all the above, please sign, date and return this form to HealthChoice at the address listed at the top of this form or fax it to 405-416-1791.

If YES to any of the above, you need to complete this form and return it to HealthChoice.

If you have other group insurance besides HealthChoice, you must provide information about your other coverage so HealthChoice can coordinate benefits with your other plan. Do not leave any portion of this form blank and be sure to list the policy effective date as the earliest date of the policy. Also, list the policy termination date, if applicable. Failure to return this form in a timely manner will result in the delay or denial of your claims.

Other Insurance Information

(1) Policy Holder's Name: _____
Date of Birth: _____

(2) Employer: _____

(3) Insured's Other Group Insurance Company: _____
Policy Number: _____

(4) Insurance Company's Address:

Phone Number: _____

(5) Effective date: _____ Termination Date: _____

(6) Coverage Status: Active _____ Retired _____ Terminated _____

(7) Coverage: Single _____ Family _____

(8) Does the plan provide coverage for: Medical () YES () NO
Dental () YES () NO

