Louisiana

OTHER COVERAGE QUESTIONNAIRE FOR OGB HEALTH PLANS

Post Office Box 98027
Baton Rouge, Louisiana 70898-9917

Customer Service: 1-800-392-4089 Fax: 1-225-298-7772

RESPONSE REQUIRED

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 regardless if you have other health care coverage or not. 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 ID Number: _____

Group Number: ST222ERC

In addition to your Blue Cross and Blue Shield of Louisiana plan coverage, are/were you, your spouse, or dependent children covered by another group health insurance plan (do not list Medicare)., including any other Blue Cross and Blue Shield coverage?

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

SECTION A – OTHER INSURANCE

Are you or any other dependent covered by another medical insurance policy?

❑ No If No, please complete section C, sign, date and return this questionnaire to us, including "No other insurance."

❑ Yes If Yes, please complete all of the fields below that pertain to the member(s) that has the other coverage

Other Insurance Carrier's Name			Policy ID Number
Address			
City	State	Zip	Phone Number

NAME(S) OF DEPENDENTS ON POLICY

Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number

Policyholder's Name	Date of Birth
Original Effective Date of Other Insurance	If Cancelled, Cancellation Date

Is the policyholder:

❑ Actively working for the group ❑ Inactive

❑ Retired, retirement date: _____ ❑ On COBRA, which began :_____

Member's Employer			
Address			
City	State	Zip	Phone Number

-SEE OTHER SIDE-

SECTION B – COURT ORDER INFORMATION If this does not apply, skip to Section C	
Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? ❑ Yes ❑ No	
List the name(s) of the dependent(s) that this applies to	
If yes, who is the person(s) listed to maintain health coverage?	
What is the relation to the children?	Who has custody of the child(ren) more than 50% of the time?
Documentation of the court order may be requested from your Health Plan Administrator.	

SECTION C	
I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
INSURED'S SIGNATURE	INSURED'S SOCIAL SECURITY NUMBER
DATE	SPOUSE'S NAME
INSURED'S DAYTIME TELEPHONE NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER