Providence Health Plan

Providence Other Medical Insurance Coverage Questionnaire

Thank you for your membership with Providence Health Plan. Please complete the questionnaire below to submit your Other Medical Insurance Information.

While covered under a Providence Health Plan, have you or any other family member(s) also had coverage under another medical insurance?

☐ Yes ☐ No

If no, please sign, date, and return this form:

Signature: _____

Date: _____

If yes, please complete the following applicable sections.

Please complete the following information for any other health insurance policy:

Name of person carrying other policy: _____

Birthdate: _____

Members covered: _____

Insurance company name: _____

Insurance company phone: _____

Providence Health Plan

Member ID number _____

Group number: _____

Coverage start date: _____ Coverage end date: _____

Name of employer providing coverage: _____

Coverage includes: ☐ Medical ☐ Vision ☐ Prescription

Type of coverage: ☐ Group plan ☐ Individual plan ☐ Retirement plan

☐ COBRA ☐ VA benefits ☐ Other: _____

Dependent Children

Has the custody of any dependent(s) covered under this plan been determined by a court or divorce decree? ☐ Yes ☐ No

If yes, please provide a copy of court order or divorce decree, which names the "Petitioner" and "Respondent."

Medicare

Are you, your spouse, or your dependent(s) eligible for Medicare? ☐ Yes ☐ No

If entitled to Medicare but have not enrolled, please provide the reason why:

_____

_____

_____

Is Medicare due to:

Age ☐ Yes ☐ No

Disability ☐ Yes ☐ No

ESRD ☐ Yes ☐ No Date of dialysis: _____

Providence Health Plan

Your Medicare ID number: _____

Part A: ☐ Yes ☐ No Effective date: _____

Part B: ☐ Yes ☐ No Effective date: _____

Part D: ☐ Yes ☐ No Effective date: _____

Spouse's Medicare ID number: _____

Part A: ☐ Yes ☐ No Effective date: _____

Part B: ☐ Yes ☐ No Effective date: _____

Part D: ☐ Yes ☐ No Effective date: _____

Dependent's Medicare ID number: _____

Part A: ☐ Yes ☐ No Effective date: _____

Part B: ☐ Yes ☐ No Effective date: _____

Part D: ☐ Yes ☐ No Effective date: _____

I certify that the above statements are true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Return completed form:

Online: visit our secure website http://www.myprovidence.com

- Navigate to My Health Plan
- Select Additional Insurance Form

Email: phpcobletter@providence.org with your Member ID# in the subject line

Mail: 3601 SW Murray Blvd. Beaverton, OR 97005 Attn: OFT

Fax: 503-574-8621