



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.

Post Office Box 98029
Baton Rouge, Louisiana 70898-9029

**OTHER COVERAGE QUESTIONNAIRE
RESPONSE
REQUIRED**

Customer Service: 1-800-599-2583 Fax: 1-225-298-2972

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. A return envelope has been provided, as well as toll-free customer service phone numbers and facsimile numbers. Thank you for your prompt response.

Please check all that apply to you as the policy holder:

<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> RETIRED
If retired, please provide a retired date ____ / ____ / ____	
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE/WIDOWED
<input type="checkbox"/> DIVORCED/LEGALLY SEPARATED	

In addition to your Blue Cross and Blue Shield Plan of Louisiana coverage, are/were you, your spouse, or dependent children covered by Medicare or another group health insurance plan (including any other Blue Cross and Blue Shield coverage?)

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

Yes: Medicare Coverage – Please Complete

Are you or your dependent(s) enrolled in any of the following Medicare Programs? **If yes**, please check the applicable answers and provide the effective dates.

SELF

Name of Beneficiary (Insured): _____ Medicare ID Number: _____

Male Female Date of Birth: ____ / ____ / ____

Reasons for Medicare: Age Disability Disability/ESRD ESRD First Dialysis ____ / ____ / ____

Part A – Hospital: No Yes ____ / ____ / ____

Part B – Medical: No Yes ____ / ____ / ____

Part C – Medicare Advantage Plan: No Yes ____ / ____ / ____

Part D – Pharmacy: No Yes ____ / ____ / ____ **If yes for Part D**, please provide the following information from your Prescription Drug Plan Identification Card:

Rx Member ID Number _____ Rx Group Number _____

Rx BIN Number _____ Rx PCN Number _____ Phone Number _____

DEPENDENT

Spouse **Child** **Other** _____

Name of Beneficiary (Insured): _____ Medicare ID Number: _____

Male Female Date of Birth: ____ / ____ / ____

Reasons for Medicare: Age Disability Disability/ESRD ESRD First Dialysis ____ / ____ / ____

Part A – Hospital: No Yes ____ / ____ / ____

Part B – Medical: No Yes ____ / ____ / ____

Part C – Medicare Advantage Plan: No Yes ____ / ____ / ____

Part D – Pharmacy: No Yes ____ / ____ / ____ **If yes for Part D**, please provide the following information from your Prescription Drug Plan Identification Card:

Rx Member ID Number _____ Rx Group Number _____

Rx BIN Number _____ Rx PCN Number _____ Phone Number _____

Yes: Other Group Health Insurance – Please Complete

Name of policyholder of other insurance: Last _____ First _____ M.I. _____ Male Female

Date of Birth: _____ Social Security Number: _____ Relationship to You: Self Spouse Dependent Other _____

Name of other insurance company: _____

Address of other insurance company: _____

Phone Number of other insurance company: _____

Policy or Group Number: _____ Effective Date: _____ / _____ / _____

Name of group or employer issuing this coverage: _____

Phone number of group or employer issuing this coverage: _____ Termination date if applicable: _____ / _____ / _____

Employment status of covered person: Active Retired on: _____ / _____ / _____

Please check all types of coverage that apply:

- Hospitalization Medical/Surgical Prescription Drug Major Medical
 Mental Conditions/Substance Abuse Dental Vision

This policy covers: Policyholder Only Policyholder and Spouse Policyholder and Children Family

If the above policy covers dependent children, please complete the following:

- Yes No Parents are married
 Yes No Parents are divorced/legally separated
 Yes No Divorced/legally separated parents have joint custody
If no, who is the legal parent with majority custody? Mother Father Other _____

Is there a legally binding agreement stating that the parent **without** majority custody has primary responsibility for the child's health care expenses? Yes No

If so, please provide the effective date of the agreement: _____

Name of responsible parent: _____

**I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE,
CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Subscriber's Signature: _____ Date: _____

Spouse's Name: _____ Daytime Telephone Number: _____