Eliance Health Solutions
Powered by Penn Medicine

OTHER INSURANCE COVERAGE QUESTIONNAIRE

Subscriber Name: _____ Employer Name: _____

Family ID #: _____

Your health plan contains a Coordination of Benefits (COB) provision. This determines which plan is primary when more than one plan covers the individual. Please complete this form as soon as possible and return to Eliance Administrators to prevent a delay in processing your or your family's medical claims. If any of the below information changes, please contact our office immediately.

Are you, your spouse or any dependent(s) covered by another health insurance plan or Medicare?

☐ **NO** (If no one else on this policy is covered by any other insurance or Medicare, please skip to section 3)

☐ **YES** (If YES, complete Section 1 for other insurance carriers OR section 2 for Medicare policies)

SECTION 1 – OTHER HEALTH INSURANCE OR HEALTH PLAN INFORMATION		
Mark Those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance What Type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental		
Other Insurance Subscriber Name	Subscriber Date of Birth	ID Number
Other Insurance Carrier Name		
Phone Number	Dependent(s) listed on the other insurance	
Effective Date of Other Insurance (if cancelled, cancellation date)		
Is the subscriber actively working for the group? ☐ Yes ☐ No	Is the subscriber inactive? ☐ Yes ☐ No	
Retired: ☐ Yes ☐ No Retirement Date _____	On COBRA? ☐ Yes ☐ No Effective Date_____	
Subscriber Employer (name, address, phone #)		
If the patient is your child, please provide the following:		
Patient's name	Patient's Date of Birth	
Father's name and Date of Birth	Mother's name and Date of Birth	
If divorced, legally separated, or a single parent, please provide the following:		
Is there a court order establishing which parent has primary responsibility for the child's health care expenses? ☐ Yes ☐ No If yes, please provide the effective date of the order: _____		
If yes, who is listed to maintain health coverage?		
List the name(s) of the dependent(s) this applies.		
Who has custody of the dependent(s)?		

SECTION 2 – MEDICARE INFORMATION (f this does not apply, skip to section 3)		
Do you or another family member have Medicare? ☐ Yes ☐ No		
Name of Person(s) with Medicare		Medicare Number, including alpha character(s)
Effective Date of Medicare Part A	Effective date of Medicare Part B	Effective date of Medicare Part D
Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*		
*If the reason is for disability or ESRD, please provide the following:		
First Date of Disability	First Date of Dialysis for ESRD	
Has a transplant been performed? ☐ Yes ☐ No If yes, please provide the date of the transplant _____		
SECTION 3		
I certify that the information provided on this form is correct and I understand that I am obligated to provide this information according to the provisions of my health plan. I also understand that I must notify my employer, in writing, if there are any changes to the information I provided above. My failure to provide complete and accurate information may result in a delay in the processing of my claims for benefits.		
Employee Signature		**Date**

Caution: Any person who knowingly and with the intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.

Please return completed form to:

Eliance Administrators
PO Box 7046
Lancaster, PA 17604-7046

Fax: 717-553-1125
Questions? Call 717-553-1124 or 1-855-408-8503