

# Other Health Insurance Form

Enrollment Department  
Phone 800.585.5883, Option 1  
Fax 206.326.2458



1200 12th Avenue S | Seattle, WA 98144

Dear US Family Health Plan Member:

US Family Health Plan (USFHP) is required by the Department of Defense to obtain information about other health insurance you or your dependents may have. If you and/or another family member have other health insurance, including Medicare, please answer the questions below and on the back of this letter and return it to us in the enclosed postage-paid envelope. If you or your family member(s) do not have other health insurance, please respond to question one, sign and date the back page of this letter, and return it to us in the enclosed postage-paid envelope. You may also fax it to us at 206-326-2458.

1. Are you or any dependents on this policy covered by another health care plan, HMO, or Medicare?  Yes  No

► **If YES, please complete the following. If NO, sign and return this form.**

2. Is your other health insurance coverage Medicare?  Yes  No

Subscriber Medicare Claim Number, including suffix: \_\_\_\_\_

Subscriber Medicare Eligibility Dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Dependent Medicare Claim Number, including suffix: \_\_\_\_\_

Dependent Medicare Eligibility Dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Subscriber's Working Status:  Active  Retired Date Retired \_\_\_\_\_

3. If your other health insurance coverage is not Medicare, please complete the following:

Name of Other Insurance Company: \_\_\_\_\_

Address of Other Insurance Company: \_\_\_\_\_

Telephone Number of Other Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name of Employer Providing Coverage: \_\_\_\_\_

CONTINUED ON OTHER SIDE ►

4. This policy provides the following benefits (check all that apply):

- Pharmacy     Dental     Vision     Mental health     Durable medical equipment

5. If your Other Health Insurance provides a pharmacy benefit, please provide the following information.

RX: group number: \_\_\_\_\_

BIN Number: \_\_\_\_\_

6. Please list who is covered by your other insurance company policy:

Name	Gender	Relationship to Policyholder	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Your Signature** \_\_\_\_\_

Date \_\_\_\_\_ Daytime Phone \_\_\_\_\_