COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.
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PATIENT NAME.

Account #

DOB.

Verification of Other Coverage from Participant

Plan Participant must provide the following information regarding other health coverage which must be verified annually. Claim Closed. To reopen, Plan Participant must complete questionnaire and return to our office.

Are any of your dependents covered by another health insurance or health plan?

* _____ No. If no other coverage, please sign and date below.

_____ No. If previous coverage terminated, provide termination date: ____/____/____ . Please sign and date below

_____ Yes. If other coverage, please provide the following information for the primary person (Employee) covered by the other Plan:

Name: _____ Date of birth: ____/____/____

SS or ID number: ____/____/____ Local Union #: _____

Effective date: ____/____/____

Active Employee? Yes ___ No ___ If Yes, hire date: ____/____/____

Retired Employee? Yes ___ No ___ If Yes, retirement date: ____/____/____

Name of employer or organization providing other coverage:

_____

Plan name, address and phone number: _____

Group number or policy number of other coverage: _____

Please circle Plan type: Group Individual

Please circle coverage provided: (Medical) Dental Vision

Is this an HMO - you must use certain providers? Yes ____ No ____

Does this Plan include dependent coverage? Yes ____ No ____

If yes, list dependents covered: _____

I hereby certify that the foregoing statements are to the best of my knowledge and belief, true, correct and complete. If this statement changes in any way, I agree to contact your office immediately.

_____ ____/____/____
Signature Date

Any person making a willful misrepresentation in completing this form shall be liable to the Plan for any loss to the Plan resulting from such misrepresentation.