PO BOX 10909
SPRINGFIELD MO 65808

Med-Pay, Inc.

(417) 886-6886
1-800-777-9087
Fax (417) 882-3743

RE: Health Insurance Verification

CHILD DEPENDENT

ID #

GROUP # GROUP NAME

EMPLOYEE NAME

If any information listed below is incorrect, please update accordingly. Please be sure to sign and date.

Dependent Name ID# Dependent DOB

Child's Relationship to Employee

Birth Child Stepchild Foster Child Adopted Child Grandchild Other (please specify)

Are the parents of this child legally divorced? YES NO Other

If YES or OTHER, please complete Box A & B **If NO, please complete Box A only**

A
Name of Other Parent Other Parent's DOB

B
Other Parent's Address (CITY) (STATE) (ZIP)

Parent with Legal Custody Parent with Physical Custody

Other Parent's Phone Number

Copies of any legal documents including a Divorce Decree, Parenting Plan, Medical Child Support Order or any other legal documentation that refers to legal custody, physical custody, information sharing insurance and/or responsibility should be sent with this form.

While insured under this Med-Pay, Inc. policy, does your dependent have any other health insurance including Medicare and/or Medicaid? **YES** **NO** If **YES**, please provide the following:

Insurance Company: Insurance Phone #

Policy ID # Group #

Policyholder Name: Policyholder's relationship to Child:

Type of Coverage: Active Retiree COBRA Marketplace

Effective Date: Termination (or Expected Termination) Date

Medicare due to Age ESRD Disability Part A Effective Date Part B Effective Date

Insured's Daytime Phone Number (in the event Med-Pay, Inc. has additional questions)

I hereby acknowledge that the above information is true and accurate to the best of my knowledge.

Insured's Signature **Date**

<u>Please note that failure to provide this information will result in a delay and possible denial of claims.</u>

<u>PLEASE PROVIDE A COPY OF YOUR OTHER HEALTH INSURANCE CARD (IF APPLICABLE)</u>