PO BOX 10909
SPRINGFIELD MO 65808

Med-Pay, Inc.

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

RE: Health Insurance Verification

EMPLOYEE

ID # _____

Group # _____ Group Name _____

Employee Name _____

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

Employee Name	ID #	Employee DOB:
_____	_____	_____

While insured under this Med-Pay, Inc. policy, do you 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 Insured: _____

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** _____

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

PLEASE PROVIDE A COPY OF YOUR OTHER HEALTH INSURANCE CARD (IF APPLICABLE)