OTHER HEALTH INSURANCE (OHI) INFORMATION FORM

Other **H**ealth **I**nsurance (OHI) coverage is medical coverage through an employer-sponsored group plan and/or Medicare or Medicaid under which the member is covered either as an employee, retiree or dependent. Please fully complete the information below to identify whether or not you or any family member covered under this Employer's Plan has medical coverage through one of these types of plans.

If this form is not completed and returned, claims will be pended until this information is received.

EMPLOYEE	LAST NAME:		FIRST NAME:		M.I.:
Group Name:		Group Number:	Social Security Number:		Date Of Birth:
Address:			City:	State:	Zip:
Phone number: (H) _____, (W) _____ (C) _____					
OHI: ___Yes ___ No	If yes, please provide the following information:	OHI Policy Holder Name:		Policy Holder's Date of Birth:	
OHI Policy Holder relation to Employee:	__Self, ___Spouse, __ Parent, __Other (_____)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage:	___ Over 65 ___ Disabled ___ End Stage Renal Disease ___ Other _____				
OHI Policy Holder's Employer:		Group Number:		Policy ID Number:	
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					

SPOUSE	LAST NAME:	FIRST NAME:		M.I.:
Phone number: (H) _____, (W) _____ (C) _____			Social Security Number:	Date of Birth:
Spouse's Employer:		Employer's Phone Number:		Does Employer offer Health Care coverage:	___Yes ___ No
OHI: ___Yes ___ No	If yes, please provide the following information:	OHI Policy Holder Name:		Policy Holder's Date of Birth:	
OHI Policy Holder relation to Employee:	__Self, ___Spouse, __ Parent, __Other (_____)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage:	___ Over 65 ___ Disabled ___ End Stage Renal Disease ___ Other _____				
OHI Policy Holder's Employer:		Group Number:		Policy ID Number:	
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					

Please attach a copy of the ID card and/or certificates of creditable coverage for any other insurance plans. Creditable Coverage ***may*** be applicable under this plan. Please provide the Certificate of Creditable Coverage with this form, if possible. If received at a later time, provide a copy to your employer or Med-Pay as soon as received.

Please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

_____ _____

Employee Signature Date