OTHER HEALTH INSURANCE (OHI) INFORMATION FORM

(DEPENDENT CHILDREN)

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.

GROUP NAME:		GROUP NUMBER:	
EMPLOYEE LAST NAME:	FIRST NAME:	M.I.	SOCIAL SECURITY NUMBER:

CHILD #___: NAME:		Date of Birth:	
Relation to Employee:	__Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship		
Child's Address if different than Employee's:			
If dependent child is over 19, is he/she eligible for employer-sponsored health care coverage through his/her own employer or his/her spouse's employer?	___Yes ___ No		
OHI: ___Yes ___ No	OHI Policy Holder Name:		Policy Holder's Date of Birth:
OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __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:	___ 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:			
Mother's Name, Address & Phone No.:			
Father's Name, Address & Phone No.:			
**Are the Child's Parents __Separated, __Divorced, __Never Married or __Other (_____)?	Who has physical custody?		

CHILD #___: NAME:		Date of Birth:	
Relation to Employee:	__Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship		
Child's Address if different than Employee's:			
If dependent child is over 19, is he/she eligible for employer-sponsored health care coverage through his/her own employer or his/her spouse's employer?	___Yes ___ No		
OHI: ___Yes ___ No	OHI Policy Holder Name:		Policy Holder's Date of Birth:
OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __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:	___ 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:			
Mother's Name, Address & Phone No.:			
Father's Name, Address & Phone No.:			
**Are the Child's Parents __Separated, __Divorced, __Never Married or __Other (_____)?	Who has physical custody?		

If necessary, make copies and attach additional pages of this OHI Form for more dependent children.

* 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.

****** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

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

_____ _____

Employee Signature Date