PO BOX 10909
SPRINGFIELD MO 65808

Med-Pay, Inc.

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

SP DEPENDENT

RE: Health Insurance Verification

GROUP NAME: _____

EMPLOYEE NAME: _____

EMPLOYEE ID#: _____

SPOUSE NAME: _____

SPOUSE ID#: _____ SPOUSE DOB: _____

Are you legally married to this dependent? YES NO

If yes, please provide date of marriage _____ If no, please provide date of divorce _____

Is this dependent employed? YES NO
If yes, please provide name and address of the employer: _____

Is this dependent covered under any OTHER health insurance, including Medicare and/or Medicaid? YES NO

If YES, please provide the following:

Insurance Company _____ Phone Number _____

Policyholder Name _____

Policy Number _____ Policyholder ID Number _____

Effective Date _____

If Medicare, Part A Effective Date _____ Part B Effective Date _____

Please notify Med-Pay immediately if any of this information changes.

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

_____ _____
Insured Signature Date

Thank you for your prompt attention in providing this information. Please note that failure to provide this information will result in a delay of processing and payment of future medical claims.