

## Employee questionnaire: Request for other medical insurance information

This form is submitted to inform us of all medical insurance coverage available to you. If you have other insurance in addition to your coverage from New York City Employees PPO (NYCE PPO) plan, we will need your other insurance information. By coordinating benefits with all insurance carriers, the insured receives the maximum benefits available.

**Important: Your response is required.** Failure to provide the information requested on this form may delay the processing of your medical claims. **Please respond even if you have no other medical insurance coverage.**

**You can provide this information in 1 of 4 ways:**

- NYCE PPO Member Services at **212-501-4444** (TTY 711).
- Visit **nyceppo.com**. Sign in to the member portal. Select **Coverage and benefits** at the top of the page, and then select **Other medical insurance**.
- Complete this form and mail to NYCE PPO Plan, P.O. Box 21534, Eagan, MN 55121.
- Complete this form and fax to **877-293-4926**.

### Personal information

Member name \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

Member ID number \_\_\_\_\_ Claim number (if applicable) \_\_\_\_\_

Patient name \_\_\_\_\_ Name of insured \_\_\_\_\_

Phone number \_\_\_\_\_ - \_\_\_\_\_

Relationship of insured to patient    Self    Spouse    Parent    Other \_\_\_\_\_

**Does the patient have other insurance or Medicare coverage?**

**Yes – other insurance:** If you check this box, continue to the **Other insurance carrier** section of this form.

**Yes – Medicare:** If you check this box, continue to the Medicare section of this form.

**No** – If you check this box, continue to the Signature section of this form.

## Other insurance carrier

Name of the subscriber for the other insurance policy \_\_\_\_\_

Name of other insurance carrier \_\_\_\_\_ Insurance carrier phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of the employer \_\_\_\_\_

Policy number \_\_\_\_\_ Group number \_\_\_\_\_

Beginning date of coverage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End date of coverage (if applicable) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY MM DD YYYY

Other insurance covers Self Spouse Dependent Other \_\_\_\_\_

**If the patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple patients, please complete a separate form for each patient.**

Name of dependent(s) \_\_\_\_\_

Relationship of other insurance member to child Parent Stepparent Legal guardian Other \_\_\_\_\_

Child resides with Parent Stepparent Legal guardian Other \_\_\_\_\_

Person(s) with legal custody Parent Stepparent Legal guardian Other \_\_\_\_\_

Is there a court decree that has assigned primary responsibility for health care coverage? Yes No

Relationship of party with decreed responsibility Parent Stepparent Legal guardian Other \_\_\_\_\_

Name of responsible party \_\_\_\_\_

Mother's name \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

Father's name \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

## Medicare

Name of individual covered by Medicare \_\_\_\_\_ Medicare ID number \_\_\_\_\_

Date of retirement (if applicable) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Medicare Part A effective date (if applicable) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY MM DD YYYY

Medicare Part B effective date (if applicable) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

Medicare Part D prescription coverage effective date (if applicable) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

Entitlement reason Age Disability Date disability began \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

End stage renal disease First date of dialysis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Kidney transplant date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY MM DD YYYY

## Signature

Print member name \_\_\_\_\_ Member signature \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY