

MULTIPLE COVERAGE INQUIRY



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

P.O. Box 91015 • Seattle, WA 98111-9115

Your health care plan requires that we coordinate the payment of benefits with any other health insurance you or your dependents may have. Please complete this form and return it within 45 days of receipt. When additional information is required and claims are held for return of that information, we may extend the overall time taken to process the claim to include an additional 15 days. Without this additional information, we will be unable to process this claim and related claims. You may have previously given us this information; we are required to periodically verify and update it. If you have any additional questions, please call Customer Service at 1 (800) 422-7713.

Have you or any person covered under this plan had other health care coverage within the last six months, including coverage within our company or another Blue Shield plan, coverage through a retirement plan, or Medicare coverage?

- Yes If Yes, please complete the rest of this form (space has been provided on the back of this form for persons with more than one other health care plan).
- No If No, please sign and date the bottom of this form, list your telephone number, and return the form to us as soon as possible.

OTHER INSURANCE INFORMATION					
INSURANCE COMPANY NAME			Insurance Company Address (Street or PO Box, City, State and ZIP)		
Name of Policyholder		Birth Date	Employer		Identification or Policy Numbers
Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare			Date Coverage Began	If coverage is no longer in effect, give the date coverage ended	
PERSONS COVERED BY OTHER INSURANCE					
Name	Birth Date	Relationship to Policyholder	Name	Birth Date	Relationship to Policyholder
IF YOUR DEPENDENT CHILD(REN) ARE COVERED UNDER ANOTHER PLAN AND THE NATURAL PARENTS ARE DIVORCED OR SEPARATED, WASHINGTON STATE REGULATIONS REQUIRE THAT WE ASK THE FOLLOWING:					
Name of parent with custody (If parents have dual custody, indicate)			If divorced, did the court establish financial responsibility for the child(ren)'s health care?		
If Yes, Please specify the name and address of the person with responsibility:					
SUBSCRIBER'S SIGNATURE					
Signature		ID Number (if not printed above)	Date	Telephone Number	

OTHER INSURANCE INFORMATION					
Name of Insurance Company				Insurance Company Telephone Number	
Insurance Company Address (Street or PO Box , City, State, and Zip Code)					
Name of Policyholder		Date of Birth	Policyholder Identification Number	Policyholder Social Security Number	
Employer		Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____		
Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pharmacy					
Type of Policy <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B					
Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	

OTHER INSURANCE INFORMATION					
Name of Insurance Company				Insurance Company Telephone Number	
Insurance Company Address (Street or PO Box , City, State, and Zip Code)					
Name of Policyholder		Date of Birth	Policyholder Identification Number	Policyholder Social Security Number	
Employer		Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____		
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Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	

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Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	