FOUNDATION FOR MEDICAL CARE
OF TULARE & KINGS COUNTIES, INC.

3335 South Fairway
Visalia, CA 93277
(559) 734-1321
(800) 662-5502
Fax: (559) 734-3828

_____ Date: _____

_____ RE: _____

_____ GRP#: _____

ID#: _____

OTHER HEALTH INSURANCE

These questions help us determine if we should coordinate benefits with another insurance company. **YOUR PLAN REQUIRES COORDINATION OF BENEFITS WHEN ANOTHER CARRIER IS INVOLVED.** Please answer all questions that apply.

1) Is patient covered by any other group accident or health insurance? ( ) Yes ( ) No
If "NO" sign and date back of form and return.
If "YES" complete the entire section AND sign and date back of form.

2) Other health insurance effective date (MM-DD-YY): _____

3) Is this ( ) Single or ( ) Family Coverage?

4) If family coverage, please give the names of all family members covered.

_____ _____

_____ _____

_____ _____

5) Is patient employed ( ) Full time ( ) Part time or ( ) not at all?

6) If part time, _____ hours a week.

7) Name and address of patient's employer:

Employer: _____

Address: _____

City/State/Zip: _____

Phone: ( ) _____

8) Does patient have group health insurance under this employer? ( ) Yes( ) No

9) If "yes" give name and address of the group health insurance company:

Company: _____

Address: _____

City/State/Zip: _____

Phone Number: ( ) _____

OVER

(10) Policy Identification Number: _____

11) Patient's Social Security Number: _____

12) Has there been a court decree issued regarding insurance coverage? ( ) Yes ( ) No

If "Yes", please explain: _____

_____

13) If the parents are separated or divorced, does the parent with custody carry insurance for patient?

( ) Yes ( ) No

Name: _____

Address: _____

City/State/Zip: _____

14) If the parents are divorced, is the parent with custody remarried? ( ) Yes ( ) No

If "Yes", does the stepparent carry group health insurance for patient? ( ) Yes ( ) No

If "Yes", please indicate the name and address of this insurance company:

Name: _____

Address: _____

City/State/Zip: _____

15) If the patient's benefits have already been determined by another insurance company, please attach the EXPLANATION OF BENEFITS (E.O.B.) form.

I HEREBY CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE.

CONTACT PHONE NUMBER WHERE YOU CAN BE REACHED_____

SIGNATURE: _____

DATE: _____

Thank you for your assistance.

Note: Your claims cannot be processed without the requested information. An envelope has been enclosed for your convenience. If you have any questions, please call Customer Service at 1-800-662-5502