COORDINATION OF BENEFITS

MERCYCARE HEALTH PLANS

MercyCare subscriber name: _____

MercyCare member number: _____

Employer group number and name: _____

Dear subscriber,
To ensure proper and timely payment of your claims, please provide the following information and return in the enclosed postage paid envelope within l5 days. Should you have any questions regarding this, or if your information should change, please call our customer service department at (800) 895-242l. Thank you for your cooperation in this important process.

l. Are you married? No ____ Yes ____ Date of birth: _____

**If yes, please answer questions 2 through 5. If no, please skip to questions 6 through 7.*

2. Is your spouse currently employed? No ____ Yes ____ Date of Birth: _____

**If yes, please provide the following:*

Employer name: _____

Phone: _____

Address: _____

3. Does your spouse have insurance through his or her employer? No ____ Yes ____

**If yes, please provide the following:*

Insurance co. name: _____

Policy/subscriber number: _____

Phone: _____

Effective date of coverage: _____

4. If you answered yes to question # 3, please advise if your spouse's insurance plan includes prescription coverage. No_____ Yes _____

**If yes, please provide the following information:*

Plan name: _____

Phone: _____Group #: _____

5. Please list all members covered by the above plan(s):

_____ _____

_____ _____

COORDINATION OF BENEFITS

MERCYCARE HEALTH PLANS

6. Are you or any of your dependents covered by Medicare? No _____ Yes _____

**If yes, please fill in the information below.*

Name: _____ Effective date: _____

Policy/subscriber number:_____

Medicare Part A effective date_____

Medicare Part B effective date_____

Medicare Part D effective date_____ Drug plan name _____

Medicare claim number:_____

Name: _____ Effective date: _____

Policy/subscriber number:_____

Medicare Part A effective date_____

Medicare Part B effective date_____

Medicare Part D effective date_____ Drug plan name _____

Medicare claim number:_____

7. Are you or any of your dependents covered through another policy?

(Please include coverage dependents may have under a separated/divorce parent) No ____ Yes ___

**If yes, please provide the following:*

Insurance co. name: _____

Policy/subscriber name: _____

Insurance company name: _____ Phone number: _____

Effective date of coverage: _____

If divorced, attach a copy of the court order.

Other coverage also includes any state aid program, such as BadgerCare Plus.