Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Post Office Box 98029
Baton Rouge, Louisiana 70898-9029
Customer Service: 1-800-495-2583 **Fax:** 1-225-298-2972
Date Printed:

OTHER COVERAGE QUESTIONNAIRE

IMPORTANT DOCUMENT

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. Policy Information
Policyholder Name
Address
City State Zip

It is important that you complete and return this questionnaire. This information is required when you are covered by more than one medical insurance provider or government plan such as Medicare. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Failure to return this questionnaire will cause a delay in processing. Thank you.

Group Number: _____ Member Number: _____

SECTION A – IF YOU DO NOT HAVE OTHER INSURANCE COVERAGE ONLY COMPLETE SECTION A	
Are you or any dependent (spouse or children) covered by another medical, dental, Medicare insurance policy? This includes Blue Cross and Blue Shield coverage from another state.	
☐ **No Other Insurance for Policyholder, Spouse, and/or Children**	**If no, please sign section A, date, and return this questionnaire, after checking the box indicating "No other insurance".**
INSURED'S SIGNATURE **X**	**DATE**

THE SECTIONS BELOW ARE FOR MEMBERS WITH OTHER INSURANCE COVERAGE INFORMATION ONLY	
☐ **Yes** **Other Health Insurance Coverage**	If yes, please complete all the fields below that pertain to the member(s) with coverage. • For Medicare coverage only, please complete section B and ***sign on the back.*** • For other health insurance plans please complete section C and ***sign on the back.*** • For other health insurance plans and Medicare, complete sections B and C and ***sign on the back.***

SECTION B – MEDICARE INFORMATION

Do you and/or dependent (s) (spouse or children) have Medicare?	☐ Yes ☐ No		
Name of Medicare Insured			**Date of Birth** ___/____/_____
Name of *Policyholder*'s Employer			
Employment Status	☐ ***Actively working***		☐ ***Inactive***
	☐ ***Retired Retirement date***: __/___/____		☐ ***On COBRA Effective Date*** __/___/____
Medicare Number, including alpha character(s):			
Reasons for Medicare	☐ Age	☐ Disability	☐ End Stage Renal Disease (ESRD)
Part A Medicare - Hospital ☐ Yes ☐ No **Effective Date** __/____	**Part B Medicare - Medical** ☐ Yes ☐ No **Effective Date** __/____		**Part C Medicare Advantage Plan** ☐ Yes ☐ No **Effective Date** ___/____
Medicare Part D - Pharmacy ☐ Yes ☐ No **Effective Date** ___/___/____			
If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card			
RX Member ID Number	**RX Bin Indicator**	**RX Group Number**	**RX PCN Number** / **Phone**
Name of Medicare Insured			**Date of Birth** ___/____/_____
Name of *Policyholder*'s Employer			
Employment Status	☐ ***Actively working***		☐ ***Inactive***
	☐ ***Retired Retirement date***: __/___/____		☐ ***On COBRA Effective Date*** __/___/____

<See Other Side>

Reasons for Medicare	☐ Age	☐ Disability	☐ End Stage Renal Disease (ESRD)

Part A Medicare - Hospital	Part B Medicare - Medical	Part C Medicare Advantage Plan
☐ Yes ☐ No **Effective Date** __/____	☐ Yes ☐ No **Effective Date** __/____	☐ Yes ☐ No **Effective Date** __/____

Medicare Part D - Pharmacy ☐ Yes ☐ No **Effective Date** ___/___/____

If yes for Part D, please provide the following information from your Prescription Drug Plan Identification Card

RX Member ID Number	RX Bin Indicator	RX Group Number	RX PCN Number	Phone

SECTION C - OTHER INSURANCE COVERAGE INFORMATION

Mark those that apply: What type of policy is this?	☐ Medical Insurance	☐ Dental Insurance	☐ Student Policy

Other Insurance Policyholder's Name	*Policyholder's DOB*	*Phone*

NAME(S) OF DEPENDENTS(Spouse or Children) ON POLICY

Name	*Relationship*	*DOB*	*SEX*	*Effective Date*	*Termination Date*

Insurance Carrier's Name

Insurance Carrier's Street Address			*Policy ID Number*
City	*State*	*Zip*	*Phone*

Original Effective Date of Other Insurance ___/___/_____	*If Cancelled, Cancellation Date* ___/___/_____

Name of Policyholder's Employer	*Phone*

Employment Status	☐ *Actively working for the group*	☐ *Inactive*
	☐ *Retired Retirement Date* __/___/____	☐ *On COBRA Effective Date* ___/__/____

SECTION D - COURT ORDER INFORMATION (If this does not apply, skip to section E)

Is there a legally binding agreement stating that the parent **without** majority custody has primary responsibility for the child's health care expenses? ☐ **Yes** ☐ **No**

Is yes, please provide the effective date of the agreement? __/___/____

List the name(s) of the dependent(s) this applies. ***Note: Documentation of the court order may be requested.***

If yes, who is listed to maintain health coverage?

What is the relation to the children?	**Who has custody of the child or children more than 50% of the time?**

SECTION E

I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

INSURED'S SIGNATURE	**DATE**
X	

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)