UnitedHealthcare®

Request for Other Insurance Coverage Information

This form is submitted to inform us of all insurance coverage available to you. If you have other insurance in addition to your **UnitedHealthcare coverage**, we will need your other insurance information. By coordinating benefits with all insurance carriers, the insured receives the maximum benefits available. Please return this form either via mail to the address on the back of the Member ID card or fax to 240-379-1072.

Member Name	Date of Birth
Policy Number	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: Continue to Other Insurance Carrier section of the form

☐ YES – Medicare: Continue to Medicare section of the form

☐ NO – Go to Signature section of the form

OTHER INSURANCE CARRIER:

Name of the Subscriber for the Other Insurance policy:_____

Name of the Employer:

_____

Name of Other Insurance Carrier:

_____

Insurance Carrier phone number: _____

Policy Number: _____ Group Number: _____

*Beginning date of Coverage: _____ *End date of Coverage (if applicable):

_____

Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ 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:_____

Name and date of birth of both parents

Mother's name: _____ Date of Birth: _____

Father's name: _____ Date of Birth: _____

MEDICARE: Name of Individual Covered by Medicare:_____

Medicare ID#: _____

Date of Retirement (if applicable):_____

Medicare Part A effective date (if applicable): _____

Medicare Part B effective date (if applicable): _____

Medicare Part D Prescription Coverage effective date (if applicable): _____

Entitlement Reason: □ Age

□ Disability Date disability began: _____

□ End Stage Renal Disease First date of dialysis: _____

Kidney transplant date: _____

SIGNATURE:

Insured or Patient Name (print): _____

Signature of Insured or Patient: _____

Date: _____