Meritain Health®
an aetna company

Meritain Health: Eligibility
PO Box 853921
Richardson, TX 75085-3921

Hello,

To help us properly handle future claims, please tell us about any <u>other</u> health care coverage you and/or your dependents may have. Examples include another group plan, an individual policy, COBRA, Medicare, state programs (such as Medicaid, CHIP, etc.), Social Security benefits due to a disability, or medical expenses covered by another person due to a court order/decree.

Please complete this form and submit it by:

- Mailing it to the address above;
- Faxing it to: **1.716.541.6672**; or,
- Taking a picture of it, and emailing it to: **forms.direct@meritain.com**.

OTHER INSURANCE COVERAGE		
Group Name	Employee Name	Employee date of birth
Group number *(if you already have an ID Card from Meritain Health)*	Member ID *(if you already have an ID Card from Meritain Health)*	
Do you and/or any of your dependents have any <u>other</u> health coverage? ❑ YES Please <u>complete the appropriate section(s) on the other side of this form</u> and return. ❑ NO Please return.		

IF THERE IS <u>OTHER</u> HEALTH CARE COVERAGE,
PLEASE COMPLETE THE APPROPRIATE SECTION(S) ON THE OTHER SIDE OF THIS FORM.

Failure to return this form may result in non-payment of claims.

For each type of <u>other</u> insurance coverage you and/or your dependents have, please complete the appropriate section.

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **<u>all</u>** family members covered by this plan, and their relation to the policy holder		

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **<u>all</u>** family members covered by this plan, and their relation to the policy holder		

For coverage through: **MEDICARE**		
Name of person covered by Medicare	Medicare ID number:	
Your retirement date *(if applicable)*	Your spouse's retirement date *(if applicable)*	
Part A effective date(s)	Part B effective date(s)	Part D effective date(s)
Reason for Medicare: ❑ Over age 65 ❑ Total disability ❑ End-stage renal disease *(provide dialysis date)* _____		

COURT ORDER OR DECREE	
Covered Individuals	Effective date
Name of person responsible for medical expenses	Address of person responsible for medical expenses
Please include a copy of the legal documentation showing responsibility for medical expenses.	