Regence

PO Box 1106
Lewiston, ID 83501-1106

Uniform Medical Plan

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

MULTIPLE COVERAGE INQUIRY

If you and/or your dependents have other insurance, or if coverage existed during the last six months, please complete this form and return it as soon as possible. This includes coverage by Regence BlueShield, any other BlueCross or BlueShield coverage, any other insurance company, any retirement plans or Medicare. Note: This form may be used for PEBB and SEBB Uniform Medical Plans.

Please sign and complete the form where indicated and submit the completed form to:

Regence BlueShield
Attn: UMP Claims
PO Box 1106
Lewiston, ID 83501-1106
or by fax to: 1-877-357-3418

1. PLEASE ANSWER THIS QUESTION

Do you, or any family member covered by Uniform Medical Plan, have any other health insurance coverage or has any such coverage existed during the last six months? Include coverage by Regence BlueShield, any other company, any other Blue Shield or Blue Cross coverage, any retirement plan or Medicare.

YES ☐ If Yes, please fill out the rest of the form if there is other insurance (space has been provided on the back of this form for persons with more than one other health care plan).

NO ☐ If No, please sign and date the bottom of this form (Section 5), list your telephone number and ID number, and return the form to us as soon as possible.

2. OTHER INSURANCE INFORMATION (for Medicare, see Section 4)

Name of Insurance Company	Insurance Company Telephone Number
Insurance Company Address (Street or PO Box, City, State, and Zip Code)	

Name of Policyholder	Date of Birth	Policyholder Identification Number	Policyholder Social Security Number

Employer	Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended:_____

Type of Coverage (Please check all that apply.) ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

Type of Policy (Please check all that apply.) ☐ Group ☐ Individual ☐ Medicaid ☐ Medicare Supplement

Persons Covered by Other Insurance

Name	Date of Birth	Relationship to Policyholder	Name	Date of Birth	Relationship to Policyholder

2a. ADDITIONAL OTHER INSURANCE INFORMATION (Complete if applicable. For Medicare, see Section 4)

Name of Insurance Company	Insurance Company Telephone Number
Insurance Company Address (Street or PO Box, City, State, and Zip Code)	

Name of Policyholder	Date of Birth	Policyholder Identification Number	Policyholder Social Security Number

Employer	Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended:_____

Type of Coverage (Please check all that apply.) ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

Type of Policy (Please check all that apply.) ☐ Group ☐ Individual ☐ Medicaid ☐ Medicare Supplement

Persons Covered by Other Insurance

Name	Date of Birth	Relationship to Policyholder	Name	Date of Birth	Relationship to Policyholder

2b. ADDITIONAL OTHER INSURANCE INFORMATION (Complete if applicable. For Medicare see Section 4)

Name of Insurance Company	Insurance Company Telephone Number
Insurance Company Address (Street or PO Box, City, State, and Zip Code)	

Name of Policyholder	Date of Birth	Policyholder Identification Number	Policyholder Social Security Number

Employer	Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended:_____

Type of Coverage (Please check all that apply.) ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

Type of Policy (Please check all that apply.) ☐ Group ☐ Individual ☐ Medicaid ☐ Medicare Supplement

Persons Covered by Other Insurance

Name	Date of Birth	Relationship to Policyholder	Name	Date of Birth	Relationship to Policyholder

3. If your dependent child(ren) are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:

Name of Parent With Custody (Please indicate if parents have dual custody.)	If divorced, did the court establish financial responsibility for the children's health care? ☐ YES ☐ NO	
If Yes, specify the name of the person with financial responsibility	Date of Divorce	**INCLUDE A COPY OF THE CHILD MAINTENANCE AGREEMENT FROM THE DIVORCE DECREE.**
Address of Person With Financial Responsibility (Street or PO Box, City, State and Zip Code)		

4. Medicare: If you or any family member are covered by Medicare, please provide the following information.	
Member's Name:	Medicare HIC Number:
Part A Effective Date:	Part B Effective Date:
If coverage began before age 65, please state the reason:	
Member's Name:	Medicare HIC Number:
Part A Effective Date:	Part B Effective Date:
If coverage began before age 65, please state the reason:	
Member's Name:	Medicare HIC Number:
Part A Effective Date:	Part B Effective Date:
If coverage began before age 65, please state the reason:	

5. SUBSCRIBER'S SIGNATURE	
Subscriber's UMP ID Number	Date
Work Telephone	Home Telephone
Subscriber's Name (please print)	Subscriber's Signature