Patient Health Plan Coverage

This form collects information about a patient's health plan coverage, including if the patient has coverage under more than one plan.

Patient name _____ Date of birth (DOB) _____

Health care provider name _____ NPI (Provider to complete)_____

Section 1: Health plan information

Primary subscriber name _____ Primary subscriber DOB _____

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Member ID / policy number (Include letters) _____ Group number _____

Health plan name _____ Health plan address _____

City _____ State _____ ZIP _____

Health plan phone number _____ Coverage start date _____ Coverage end date _____

Employer name _____ Subscriber is: ☐ Active ☐ Retired ☐ on COBRA

Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare

A. Do you have coverage under another health plan?

☐ Yes, other insurance. Go to **Section 2.**

☐ Yes, Medicare. Go to **Section 3.**

☐ No other coverage. Go to **Section 4.**

Section 2: Other health plan information (Including Medicaid/CHIP)

Primary subscriber name _____ Primary subscriber DOB _____

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Member ID / policy number (Include letters) _____ Group number _____

Health plan name _____ Health plan address _____

City _____ State _____ ZIP _____

Health plan phone number _____ Coverage start date _____ Coverage end date _____

Employer name _____ Subscriber is: ☐ Active ☐ Retired ☐ on COBRA

Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare

A. If the patient is a child, provide:

Mother's name _____ DOB _____ Father's name _____ DOB _____

B. If parents are separated, divorced, or not married, list:

Child resides with _____ Relationship _____

Individual with custody _____ Relationship _____

C. Is there a court order establishing responsibility for health care coverage?

☐ No ☐ Yes

If yes, provide the following: Responsible party _____ Relationship _____

Section 3: Medicare coverage information

Medicare subscriber name _____ Medicare ID number _____

- ☐ Part A – Effective date _____
- ☐ Part B – Effective date _____
- Entitlement reason:
  - ☐ Age
  - ☐ Disability
  - ☐ End stage renal disease
    - If due to end stage renal disease, provide the first date of dialysis _____
    - ☐ Home dialysis ☐ Facility or dialysis center
    - Date of kidney transplant, if applicable _____

Section 4: Signature

_____ _____

Name of person completing the form | Relationship to patient

_____ _____

Signature | Date