KAISER PERMANENTE®

Other Coverage inquiry

By coordinating benefits for you or other family members who have additional health coverage, we may be able to reduce your out-of-pocket expenses for covered services.

Please take a moment to complete the information for each family member listed below. Indicate Yes or No if any have health coverage from a carrier other than Kaiser Permanente.

If yes, complete sections 2 and 3, provide a copy of the health plan identification cards and sign and date the bottom of the form. If no, please sign and date at the bottom of the form. Return the form to us in the enclosed postage paid envelope or fax it to: **1-509-434-3113.**

This form is also available online at **www.kp.org/wa**

1. PERSONS COVERED BY KAISER PERMANENTE

Member Number	First Name	M.I.	Last Name	Date of Birth	Other Coverage?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

2. IDENTIFY OTHER CARRIER INFORMATION

Please fill in information below pertaining to all other coverage, use backside for additional carriers.

Carrier name | Group/Plan number | Member ID number (Include alpha prefix)

Address of carrier | Phone number of carrier

Full name of subscriber/policy holder | Subscriber/policy holder date of birth | Relationship to Kaiser Permanente member

Type of Coverage: ☐ Medical ☐ Vision ☐ Pharmacy **Type of Policy:** ☐ Group ☐ Individual ☐ Self Funded ☐ Retiree ☐ COBRA

3. SUPPORT/CUSTODY INFORMATION

If your dependent child(ren) is/are covered under another plan and the natural parents are divorced or separated, we will need the following information to comply with Washington State regulations pertaining to coordination of benefits and payments:

Is either parent required by a divorce decree to carry health coverage? ☐ Mother ☐ Father ☐ Both

You must provide us with a copy of the divorce decree and/or parenting plan, and the custodial parent's name, and address and phone number, so we can determine the correct order of benefits and to whom we should send potential overpayments.

	First name	M.I.	Last name	Date of birth	Insurance name
Natural parent with custody					
Step parent with custody					
Natural parent *without* custody					
Step parent *without* custody					

I hereby certify that the above information is true and correct to the best of my knowledge.

Signature of member/subscriber | Date