PHP TPA Services
PO Box 9648, Fort Wayne, IN 46899
PH: 800-551-7334 | FAX: 260-436-7235
proclaimplus.com

Verification of Other Insurance

Member Name: ___________________________________ Patient Name: _____________________________

Member Number: _________________________________ Patient DOB: _________________________________

NOTE: Please complete this form regarding any other health coverage that you or your dependent(s) may have. When you or your dependent(s) have other health coverage, the information requested below will enable us to process your claims correctly.

Section A – OTHER INSURANCE – See Next Page for Additional Dependents

Is the patient listed above covered by another medical insurance policy?
☐ No If No, please complete section D
☐ Yes If Yes, please complete all of the fields below.

What type of policy is this?	☐ Group	☐ Individual Policy	☐ Student Policy	☐ Medicare

Other Insurance Carrier's Name	Group Number
Address	

City	State	ZIP	Telephone Number

Other Insurance Member's Name	Member's Date of Birth	ID Number

Original Effective Date of Coverage	If Cancelled, Cancellation Date

Is the member: **(Check ALL That Apply)**
☐ Actively working for the group ☐ Retired (retirement date ____________________________) ☐ Covered Under Medical ____________________
☐ Inactive ☐ On COBRA, which began on __________________________ ☐ Covered Under Dental _____________________

Section B – MEDICARE INFORMATION ***If this does not apply, skip to Section C.***

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A	Effective Date of Medicare Part B

Medicare Entitlement is due to:
☐ Age
☐ Disability First date of disability _________________________________
☐ End Stage Renal Disease (ESRD) First date of dialysis _____________________________________

Section C – COURT ORDER INFORMATION ***If this does not apply, skip to Section D.***

Is there a Court Order specifying a person(s) to maintain health coverage for the patient? ☐ Yes ☐ No

If yes, who is the person(s) listed to maintain health coverage?

What is the person(s) relationship to the patient?	Who has custody of the patient more than 50% of the time?

Please provide a copy of the court order.

Section D – CERTIFICATION

I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE, CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF.

MEMBER'S SIGNATURE	DATE	DAYTIME PHONE #

Member Name: ______________________________________ Patient Name: ______________________________

Member Number: ____________________________________ Patient DOB: ___________________________________

Section A Continued– OTHER INSURANCE – Additional Dependents

Is the patient listed above covered by another medical insurance policy?

☐ No If No, please complete section D

☐ Yes If Yes, please complete all of the fields below.

What type of policy is this?	☐ Group	☐ Individual Policy	☐ Student Policy	☐ Medicare

Other Insurance Carrier's Name	Group Number

Address

City	State	ZIP	Telephone Number

Other Insurance Member's Name	Member's Date of Birth	ID Number

Original Effective Date of Coverage	If Cancelled, Cancellation Date

Is the member: **(Check ALL That Apply)**

☐ Actively working for the group ☐ Retired (retirement date ___________________________) ☐ Covered Under Medical _____________________

☐ Inactive ☐ On COBRA, which began on ___________________________ ☐ Covered Under Dental _____________________

Member Name: ______________________________________ Patient Name: ______________________________

Member Number: ____________________________________ Patient DOB: ___________________________________

Section A Continued– OTHER INSURANCE – Additional Dependents

Is the patient listed above covered by another medical insurance policy?

☐ No If No, please complete section D

☐ Yes If Yes, please complete all of the fields below.

What type of policy is this?	☐ Group	☐ Individual Policy	☐ Student Policy	☐ Medicare

Other Insurance Carrier's Name	Group Number

Address

City	State	ZIP	Telephone Number

Other Insurance Member's Name	Member's Date of Birth	ID Number

Original Effective Date of Coverage	If Cancelled, Cancellation Date

Is the member: **(Check ALL That Apply)**

☐ Actively working for the group ☐ Retired (retirement date ___________________________) ☐ Covered Under Medical _____________________

☐ Inactive ☐ On COBRA, which began on ___________________________ ☐ Covered Under Dental _____________________