Health and Welfare Fund Office for UFCW and Employers
Fax To: 901-758-3021
Upload: www.bams.bz
Mail To: 661 N. Ericson Road Cordova TN, 38018

## CLAIMS PENDING! Verification of Other Insurance Coverage Required!

Before we can process any of your claims, we need to know if you have other medical or dental coverage under any other insurance carrier. Your response is needed even if you do not have any other coverage.

- Complete the form on the back of this letter and return it immediately along with supporting documentation.

Your UFCW Lo. 1529 and Emp. H&W Plan contains Coordination of Benefits (COB) provisions. COB is in effect when more than one group health care plan or program covers a person. It ensures that no plan/program pays more than its proper share. Additionally, it provides the correct order of payment responsibility.

Upon receipt of this required information, we will process any applicable pending claims within 30 days and notify you by way of mailing you a copy of the Explanation of Benefits that outlines the claim and payment details

Federal laws require that we make timely claim decisions, please respond within 30 days. Failure to do so could result in your healthcare provider sending you to collections.

# OTHER INSURANCE COVERAGE QUESTIONNAIRE

**Employee Name: _____ Employee Date of Birth:_____**

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**Phone Number: _____Email Address: _____**
**Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____**

**Do you or ANY of your dependents have any other medical or dental coverage?** This includes any state plans, Veteran plans, Medicare or Medicaid: **YES____ OR NO_____ If you marked YES, which indicates you or a dependent has other coverage, complete the ENTIRE section below and submit the supporting documentation outlined at the bottom of this page**:

**Name of the Policy Holder (the person who has the other insurance): _____**

1. Benefits Included in Other Coverage: Medical ☐ Dental ☐ Vision ☐
2. Policy Holder's Relationship to covered persons: Spouse ☐ Parent ☐ Step-Parent ☐
3. Policy Holder's Date of Birth (other insurance carrier): ___/____/___
4. Name of Dependent(s) covered by other insurance carrier:_____
5. Name of Other Insurance Carrier (Example: MS Medicaid/Aetna/Blue Cross Blue Shield):_____
6. Policy Number:_____ Policy Effective Date ____/____/_____Policy Termination Date ____/____/_____
7. **Name of Employer the insurance is provided by (Example: FedEx, Nike Corp., McDonald's)_____ Date of Hire with this Employer_____**
8. Is there a court order regarding health care coverage for your children? Yes____ No____
9. If you answered "Yes" please supply us with a copy of the Medical Child Support Order.
10. If there is not a courts order, who has custody of children? _____
11. Has the custody parent remarried? Yes____ No____,
12. If Yes does the step-parent have family insurance coverage? Yes_____ No_____,
13. If Yes is anyone on your policy covered by the step-parent's policy? _____
14. Biological Father's Date of Birth: _____ Biological Mother's Date of Birth:_____
15. List the children the above information applies: _____

**MEDICARE ONLY (complete below if you have Medicare Part A, B or D or any advantage plan through Medicare)**

**If Medicare ☐ Part A ☐ Part B ☐ Part D Medicare Effect Date:** ____/____/_____ **Medicare HICN:_____Reason for Medicare Entitlement:** ☐ Age ☐ Disability ☐ End Stage Renal Disease

Are you or any of your dependents covered under Medicare due to kidney failure? **Yes____ No_____**
If yes, when did kidney dialysis begin? ____/____/_____

**Additional Supporting Documentation You Must Submit:** If you or your dependents have had other insurance coverage with another carrier within 12 months of this application, you must contact that carrier and request a "**Certificate of Credible Coverage**" and submit that to our office. Additionally, if we have on file that you do have other coverage and you no longer have it, you will also need to submit a Certificate of Credible Coverage that reflects the termination date under the other policy. Lastly, please attach a copy of that carriers "Coordination of Benefits Rules."

**Attest: I have read the above and attest that statements made by me on this form are complete and true. I understand that if any of the above information changes it is my responsibility to notify the Plan Administrator in writing immediately. I understand the definition of Fraud and know that if I willingly falsify this document that I can be prosecuted for Health Care Fraud.**

**Signature: _____ Date: _____**