



Dear PEBB Member:

Providence Health Plan wants to provide you with the best customer service experience possible. **To assist us in the smooth transition of your health care coverage and avoid disruption in processing your claims, please respond to this letter promptly.**

In order to administer your benefits quickly and accurately, we need to know whether you or any of your dependent family members have additional health care coverage through another health care plan or medical insurance company in addition to your PEBB Statewide Plan.

If you have medical insurance through another source, it is important that you fill out the form on the back of this letter and return it to us as soon as possible. If you do **not** have additional health care insurance, please let us know by filling out the box below and returning this letter promptly. This will allow us to ensure your benefits are applied appropriately.

If you check “NO” in the box below, be sure to include your name and signature before returning to us. If you check “YES,” you must also complete the form on the reverse. Please provide us with this information as soon as possible so that we may process your claims correctly.

If you have questions or concerns, please contact the Providence Health Plan customer service team at 503-574-7500 or 1-800-878-4445, Monday through Friday, between 8 a.m. and 5 p.m. (TTY line for the hearing impaired: 503-574-8702 or 1-888-244-6642)

We appreciate your time and attention in completing this form.

Sincerely,

Providence Health Plan

Do you or any other family members covered under your PEBB Statewide Plan have any additional medical insurance coverage through another company or organization? Yes ____ No ____

NO: Please sign and date on the lines below, and return this letter in the enclosed envelope.

You do not need to fill out the form on the reverse.

Full name (please print clearly): _____

Date: _____ Signature: _____

YES: If you or one of your covered dependents does have medical insurance through another company or organization in addition to PEBB, please complete and return the form on the back side of this letter.

PEBB STATEWIDE PLAN COORDINATION OF BENEFITS

If you or any of your covered dependents have medical insurance coverage in addition to your PEBB Statewide Plan, please complete and return this form promptly to avoid a disruption in processing your claims. If you do not have additional medical insurance, you do not need to fill out the form below.

PEBB Member name (please print clearly): _____

Dependent children: Is there a dependent child or children covered on this plan whose custody has been determined by a court or divorce decree? Yes ___ No ___

If **Yes**, name of dependent(s): _____

Name of person(s) with legal custody: _____

Relationship to dependent(s): _____ Date of custody: ___/___/___

Name of individual ordered by court to provide health insurance coverage: _____

In order for us to follow the conditions of your court order or divorce decree, please provide a copy of the document which names the "Petitioner" and "Respondent". This information is needed in order for us to properly administer your benefits.

Medicare: Are you, your spouse or dependent/s eligible for Medicare? Yes ___ No ___

If **No**, and any of you are entitled to Medicare and have not enrolled, please provide an explanation: _____

If **Yes**, is eligibility due to: Disability Yes ___ No ___ ESRD Yes ___ No ___ Date of dialysis: ___/___/___

Your Medicare ID#: _____

Part A: Yes ___ No ___ Effective date: ___/___/___

Part B: Yes ___ No ___ Effective date: ___/___/___

Part D: Yes ___ No ___ Effective date: ___/___/___

Spouse's Medicare ID#: _____

Part A: Yes ___ No ___ Effective date: ___/___/___

Part B: Yes ___ No ___ Effective date: ___/___/___

Part D: Yes ___ No ___ Effective date: ___/___/___

Dependent's Medicare ID#: _____

Part A: Yes ___ No ___ Effective date: ___/___/___

Part B: Yes ___ No ___ Effective date: ___/___/___

Part D: Yes ___ No ___ Effective date: ___/___/___

Please complete the following information regarding any additional health insurance policy (other than your PEBB Statewide Plan) for any member/s of your family covered by your PEBB Statewide Plan.

Name of person carrying other policy: _____ Birth date: _____

Members covered: _____

Insurance company name: _____ Insurance company phone: _____

Insurance company address: _____

Member ID or social security number: _____ Group number: _____

Coverage start date: _____ Coverage end date: _____

Name of employer/organization providing coverage: _____

Coverage includes: Medical ___ Vision ___ Prescription ___ Alternative care ___

Type of coverage: Group ___ COBRA ___ Retirement plan ___ Continuation/portability ___

VA benefits ___ Other _____

I certify that the above statements are true and correct to the best of my knowledge.

Full name (please print clearly): _____

Signature: _____ **Date:** _____

Please return this completed questionnaire in the enclosed envelope or to Providence Health Plan, P.O. Box 4327, Portland, OR 97208-4327.