# Employee Questionnaire: Request for other medical insurance information

This form is submitted to inform us of all medical insurance coverage available to you. If you have other insurance in addition to your coverage from UMR, we will need your other insurance information. By coordinating benefits with all insurance carriers, the insured receives the maximum benefits available.

**Important: Your response is required.** Failure to provide the information requested on this form may delay the processing of your medical claims. **Please respond even if you have no other medical insurance coverage.**

**You can provide this information in one of four ways:**

- Call the number on your ID card to speak with a representative
- Visit **umr.com**. Log in to your member portal and click the **Other medical insurance** tile
- Complete this form and **mail** to **UMR**, P.O. Box 30541, Salt Lake City, UT, 84130-0541
- Complete this form and **fax** to **877-293-4926**

## Personal information

Member name ______________________ Date of birth ____/____/____ (MM DD YY)

Member ID number ______________________ Claim number *(if applicable)* ______________________

Patient name ______________________ Name of insured ______________________

Phone number ____-____-____

Relationship of insured to patient Self Spouse Parent Other ______________________

**Does the patient have other insurance or Medicare coverage?**

**Yes – other insurance:** If you check this box, continue to the Other Insurance Carrier section of this form.

**Yes – Medicare:** If you check this box, continue to the Medicare section of this form.

**No** – If you check this box, continue to the Signature section of this form.

*(Continued)*

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## Other insurance carrier

Name of the subscriber for the other insurance policy ______________________

Name of other insurance carrier ______________________ Insurance carrier phone ___ - ___ - ___

Name of the employer ______________________

Policy number ______________________ Group number ______________________

Beginning date of coverage ___ / ___ / ___ (MM DD YY) End date of coverage *(if applicable)* ___ / ___ / ___ (MM DD YY)

Other insurance covers Self Spouse Dependent Other ______________________

**If the patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple patients, please complete a separate form for each patient.**

Name of dependent(s) ______________________

Relationship of other insurance member to child Parent Stepparent Legal guardian Other ___________

Child resides with Parent Stepparent Legal guardian Other ______________________

Person(s) with legal custody Parent Stepparent Legal guardian Other ______________________

Is there a court decree that has assigned primary responsibility for health care coverage? Yes No

Relationship of party with decreed responsibility Parent Stepparent Legal guardian Other ___________

Name of responsible party ______________________

Mother's name ______________________ Date of birth ___ / ___ / ___ (MM DD YY)

Father's name ______________________ Date of birth ___ / ___ / ___ (MM DD YY)

## Medicare

Name of individual covered by Medicare ______________________ Medicare ID number ___________

Date of retirement *(if applicable)* ___ / ___ / ___ (MM DD YY) Medicare **Part A** effective date *(if applicable)* ___ / ___ / ___ (MM DD YY)

Medicare **Part B** effective date *(if applicable)* ___ / ___ / ___ (MM DD YY)

Medicare **Part D** prescription coverage effective date *(if applicable)* ___ / ___ / ___ (MM DD YY)

Entitlement reason Age Disability Date disability began ___ / ___ / ___ (MM DD YY)

End stage renal disease First date of dialysis ___ / ___ / ___ (MM DD YY) Kidney transplant date ___ / ___ / ___ (MM DD YY)

## Signature

Print employee name ______________________ Employee signature ______________________

Date ___ / ___ / ___ (MM DD YY)