Other Insurance (Coordination of Benefits) Questionnaire

Subscriber Name	
Patient Name	
Employer Name	
Member ID Number	

Our records indicate the patient may have other insurance that could affect the benefits payable under your True Health New Mexico Plan. Providing the information requested will help avoid any delays in processing your family's health claims. **If coverage has terminated, please provide your letter of creditable coverage provided by the other insurance company.**

Please complete the information below, sign, and return to the address at the bottom of this form. Thank you.

Is the patient covered by Medicare?	☐ NO ☐ YES (If YES, please submit a copy of the patient's Medicare card.)
Is the patient covered by any other health insurance in addition to this True Health New Mexico Plan?	☐ NO ☐ YES (If YES, please complete the information below.)
Name of Insured Person	
Relationship to the Patient	
Employer Name and Address	
Employer Telephone Number	( )
Insurance Co. Name and Address	
ID Number and Group Number	
Insurance Co. Telephone Number	( )

TYPES OF COVERAGE	**SINGLE/FAMILY**	**EFFECTIVE DATE/CANCELLATION DATE**
Medical: ☐ Yes ☐ No	S ☐ / F ☐	___________________/_____________________
Dental: ☐ Yes ☐ No	S ☐ / F ☐	___________________/_____________________
Vision: ☐ Yes ☐ No	S ☐ / F ☐	___________________/_____________________
Rx Card: ☐ Yes ☐ No	S ☐ / F ☐	___________________/_____________________

Insured's date of birth: _____________ Active Employee Plan: ☐ Retired Employee Plan: ☐

Birthday Rule: ☐ Yes ☐ No Coordination of Benefits Provision: ☐ Yes ☐ No

Signature: ____ Date: _____________________________

Please send completed form to:

- Via mail: True Health New Mexico, P.O. Box 211468, Eagan, MN 55121
- Via email: info@truehealthnewmexico.com
- Via fax: 1-312-548-9943

If you have any questions, please call True Health New Mexico Customer Service at 1-855-769-6642.