BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

2301 MAIN ST • PO BOX 419169
KANSAS CITY, MO 64141-6169

OTHER COVERAGE PROFILE

PRINT POLICYHOLDER NAME:_____MEMBER ID#_____

Blue Cross and Blue Shield of Kansas City must have this information annually to process claims on your behalf. Please complete the questions below or visit our website, www.bcbskc.com.

Do you or your family members have other health and/or dental coverage, including Medicare, in addition to the policy listed above? (Please check one)

- ☐ **Yes** If Yes is marked, you may answer the questions in section A and mail your response to the address shown at bottom of page **or** visit our website, www.bcbskc.com.
- ☐ **No** If no is marked, you may sign the statement below and mail your response to address shown at bottom of page **or** call our interactive response line using the instructions below **or** visit our website, www.bcbskc.com.

I certify that my family members and I **do not** have other health and/or dental coverage, including Medicare, in addition to the policy listed above. To respond, please sign, date and mail this page to Blue Cross Blue Shield of Kansas City, Member Services A3A1, P. O. Box 419169, Kansas City, MO 64l41-6169

_____ _____
Member Signature Date

INSTRUCTIONS FOR TELEPHONE INTERACTIVE RESPONSE LINE

- Use this method for "**NO**" **answers only** when you and all your family members have no other coverage.
- Please be prepared to enter your member ID number (located on your ID card).
- Please be prepared to enter the date of birth of the Policyholder.
- Dial (816) 395-3774 or 1-800-405-7477
- Enter your information when instructed.

Section A – Instructions for YES response. Answer all three questions.

1. Do you or your family members have **Medicare** insurance as other coverage?
   ☐ NO ☐ YES (If yes, complete **Section B**)
2. Do you or your family members have other health and/or dental insurance coverage (including any other Blue Cross and Blue Shield plan)?
   ☐ NO ☐ YES (If yes, complete **Section C**)
3. Are any of your family members currently subject to a divorce decree or court order?
   ☐ NO ☐ YES (If yes, complete **Section D**)

Please proceed to the backside of this sheet to complete **Section B, C, and/or D** if applicable.

If mailing form, send to Blue Cross Blue Shield of Kansas City
Member Services A3A1
P. O. Box 419169
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Section B – Medicare Information (include copy of Medicare cards if possible)

Medicare Beneficiary #1 Name: _____ Medicare HIC # _____
(Name)
Date of Birth: _____ Part A Effective Date: _____ Part B Effective Date: _____

Medicare Beneficiary #2 Name: _____ Medicare HIC # _____
(Name)
Date of Birth: _____ Part A Effective Date: _____ Part B Effective Date: _____

If you or your spouse are not actively working, please indicate retirement date(s):
You _____ Spouse _____

Do you have Medicare due to end-stage renal disease ☐ and/or disability ☐ ?

Does your spouse have Medicare due to end-stage renal disease ☐ and/or disability ☐ ?

Section C – Other Health and/or Dental Insurance Coverage Information

Other Insurance Carrier Name: _____

Policy # _____ Effective Date: _____

Policyholder's Name: _____ DOB: ___/____/___ SSN _____

Type of coverage: _____Medical and Dental _____Medical Only _____Dental Only

List other members covered by this policy:

Name_____ SSN _____ DOB: ___/____/___

Name_____ SSN _____ DOB: ___/____/___

Name_____ SSN _____ DOB: ___/____/___
If you need more space, please attach another sheet.

Section D – Divorce Decree or Court Order Information

If divorce decree states that a parent **must** provide medical and/or dental insurance for the dependent, what is the name and date of birth of the parent responsible?

Name of Dependent	DOB	Responsible Parent	DOB
_____	__/___/___	_____	___/____/___
_____	__/___/___	_____	___/____/___

Please send a copy of the portion of the divorce decree or court order indicating responsibility.

To ensure we have the correct number in the event we need to contact you, please provide a daytime phone number where you can be reached between 8:00 a.m. and 4:30 p.m., Monday through Friday.
I CERTIFY THAT THE INFORMATION GIVEN IS COMPLETE AND TRUE.

Print Name: _____ Daytime phone ( ) _____-_____

Member ID# _____

Member Signature: _____ Date: _____