

This form letter is designed to assist Integra BMS in accurately processing your claims under the group health plan. Please fully complete all applicable sections and mail this form back to Integra BMS at the address listed below.

Group (Employer) Name:	
Employee Name:	
Employee ID:	
Patient Name:	

Child Custody Information Section

	Question	Yes or No <i>(circle one and follow directions)</i>	
1	Are you divorced or legally separated from your child's other parent?	Yes	No
2	Does the other parent have custody of the child?	Yes	No
3	Is there a court order or other legally binding document (divorce decree, etc.) which describes which parent is responsible for the medical expenses of the child?	Yes <i>Please submit a copy of the document to Integra BMS. You may fax along with this form to Integra BMS.</i>	No
4	Is there any other medical insurance which covers your child?	Yes <i>Please complete the information requested in section #5.</i>	No
5	Please provide the following information regarding the other insurance which is in force on your child: 1. Name of insurance company: _____ 2. Name of the policyholder: _____ 3. Policy number: _____ 4. Effective date of other insurance: _____ Termination date (if termed): _____ 5. Address of other insurance company: _____ 6. Phone number of other insurance company: _____		

Please use this section to provide Integra BMS with any other information which you believe will assist Integra BMS in accurately processing the claim(s) on this dependent:

Employee Certification and Signature

I hereby certify that all information on this claim is accurate and that no information has been omitted.

Employee Signature	Date
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Please mail the completed form to Integra BMS at:

Integra BMS
 Attn: Eligibility Department
 P.O. Box 1178
 Matthews, NC 28106