Integra BMS Other Insurance Coverage Information

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:	

Other Insurance Coverage Information Section

	Question	Yes or No *(circle one and follow directions)*	
1	Please provide the full name and member ID of your spouse in the space provided to the right →	____ please write your spouse's name here ____ please write your spouse's Member ID here	
2	Is your spouse employed now or has your spouse been employed within the last 6 months?	**Yes** **please complete section #3**	**No** **Skip to section #4**

3 Please provide the following information regarding your spouse's employment.

1. Name and telephone number of spouse's employer: ____
2. Does your spouse's employer provide health insurance? YES [ ] NO [ ]
3. If "Yes", provide the name and phone number of the insurer or administrator of the employer's Plan:
4. If "Yes", provide the policy and/or contract number of this Plan:
5. Please list all members of your family who are covered under this plan and check the types of coverage in force:

Name	Medical	Dental	Vision	Other: ( )
_______________________	Yes No	Yes No	Yes No	Yes No
_______________________	Yes No	Yes No	Yes No	Yes No
_______________________	Yes No	Yes No	Yes No	Yes No
_______________________	Yes No	Yes No	Yes No	Yes No

4	Is the Patient listed above covered by any other medical, dental, or vision plan, including Medicare?	**Yes** **Please compete section #5**	**No** sign in the employee certification section

5 Please provide the following information regarding the Patient's other insurance or Medicare:

1. Name and telephone number of patient's other insurance carrier: ____________________________________
2. Effective date of other medical, dental, or vision insurance: ____
3. Please provide any other pertinent information in the space below:

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**

Please mail the completed form to Integra BMS at:

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

Phone 800-228-1803 fax 704-845-5629 integrahealth.com