

HEALTHFIRST Third Party Administrators

www.hftpa.com

*****PLEASE TYPE OR PRINT***
(Co-ordination of Benefits Form)**

Dear Insured:

The claim you recently submitted is being processed. We are updating your file regarding other insurance information. Please complete and return this form within seven days to avoid future claims from being delayed or rejected. All applicable information must be completed before claim can be considered.

If you have any questions regarding this form, please contact Client Services at 1-800-477-2287 or locally at 903-581-2600.

EMPLOYEE NAME: _____

EMPLOYER: _____

GROUP NUMBER (refer to enclosed EOB) : _____

1. IF MARRIED, IS YOUR SPOUSE EMPLOYED? YES ____ NO ____
NOT MARRIED _____
IF YES, FULL TIME _____ PART TIME _____
EMPLOYER'S NAME _____
PHONE NUMBER _____

2. DO YOU OR ANY OTHER FAMILY MEMBER HAVE OTHER GROUP **MEDICAL** INSURANCE?
YES _____ NO _____
IF YES, PLEASE CONTINUE. IF NO, PLEASE GO TO QUESTION #3.

WHICH FAMILY MEMBERS? _____

NAME OF OTHER INSURANCE COMPANY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER () _____ POLICY NUMBER _____

FAMILY COVERAGE _____ SINGLE COVERAGE _____

POLICYHOLDER'S NAME _____

POLICYHOLDER'S GROUP/POLICY NUMBER _____

BIRTHDATE _____

EFFECTIVE DATE _____

TERMINATION DATE (IF APPLICABLE) _____

3. DO YOU OR ANY OTHER FAMILY MEMBER HAVE OTHER GROUP **DENTAL** INSURANCE?
YES _____ NO _____
IF YES, PLEASE CONTINUE. IF NO, PLEASE GO TO QUESTION #4.

WHICH FAMILY MEMBERS? _____

NAME OF OTHER INSURANCE COMPANY _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER () _____ POLICY NUMBER _____

FAMILY COVERAGE _____ SINGLE COVERAGE _____

POLICYHOLDER'S NAME _____
POLICYHOLDER'S GROUP/POLICY NUMBER _____
BIRTHDATE: _____
EFFECTIVE DATE: _____
TERMINATION DATE (IF APPLICABLE) _____

4. IF DIVORCED OR SEPARATED, WHO HAS CUSTODY OF THE CHILDREN?
MOTHER _____ FATHER _____ DOES NOT APPLY _____

IS THERE A DIVORCE DECREE/COURT ORDER WHICH OUTLINES INSURANCE
RESPONSIBILITIES?
YES _____ NO _____

***IF YES, PLEASE ATTACH A COPY OF THIS PORTION OF THE DECREE
(UNLESS PREVIOUSLY SUBMITTED)***

5. ARE YOU OR ANY OTHER FAMILY MEMBER ELIGIBLE FOR MEDICARE?
YES _____ NO _____
IF YES, WHO? _____ EFFECTIVE DATE: _____

I HEREBY DECLARE AND AGREE THAT THE ABOVE ANSWERS ARE, TO THE BEST OF MY
KNOWLEDGE AND BELIEF, COMPLETE AND TRUE.

NAME (please print): _____
EMPLOYER (please print): _____
SIGNATURE: _____ DATE: _____

HEALTHFIRST TPA
CLAIMS DEPARTMENT
P.O. BOX 130217
TYLER, TX 75713-0217