HealthNow Administrative Services

P.O. Box 211034
Eagan, MN 55121
Phone: 877-804-4629

Other Coverage Verification

COMPLETION OF THIS INFORMATION WILL HELP TO AVOID UNNECESSARY CLAIM DELAYS

EMPLOYEE INFORMATION:

Employee Name:	Employee Identification Number:

VERIFICATION OF OTHER MEDICAL COVERAGE:

I certify the following information with regard to medical coverage under another group insurance plan:

Is the employee covered by another group medical plan? ☐ Yes ☐ No

Effective date of employee's medical coverage _____/_____/_____ Termination date _____/_____/_____

Is the employee eligible for Medicare? ☐ Yes ☐ No

Effective date Part A _____/_____/_____ Effective date Part B _____/_____/_____

Employee current status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

specify_____

DEPENDENT INFORMATION:

Spouse Name:	Spouse's date of birth (mm/dd/yyyy):	Is spouse employed? ☐ Yes ☐ No

Are dependents covered by another medical insurance? ☐ Yes ☐ No

If yes:
Name of principal insured: _____

Name of the insurance company: _____

Address: _____

_____

Group Number: _____ Effective date of dependent coverage _____/_____/_____

Termination date of dependent coverage _____/_____/_____

Are dependents eligible for Medicare or any other government program? ☐ Yes ☐ No

If yes:
List dependents: _____

_____

Effective date of coverage _____/_____/_____ Name of program _____

(please include copy of insurance card)

DEPENDENT INFORMATION (continued):

If you have selected single, divorced, or separated as the employee status on the previous page, please complete the information below with regard to dependent children:

Complete name of natural father: _____ Date of birth: _____/_____/_____

Address: _____

_____

Full name of natural father's employer: _____

Address: _____

_____

Does the natural father's employer provide medical coverage for the dependent? ☐ Yes ☐ No
Does the natural father's employer provide dental coverage for the dependent? ☐ Yes ☐ No

If yes, please provide the name, address and phone number of the insurance carrier: _____

_____

Complete name of natural mother: _____ Date of birth: _____/_____/_____

Address: _____

_____

Full name of natural mother's employer:_____

Address: _____

_____

Does the natural mother's employer provide medical coverage for the dependent? ☐ Yes ☐ No
Does the natural mother's employer provide dental coverage for the dependent? ☐ Yes ☐ No

If yes, please provide the name, address and phone number of the insurance carrier:

_____

Is there a court decree establishing the custody of the dependent along with a provision for medical dental benefits? ☐ Yes ☐ No

If yes, please advise which parent has custody and forward a copy of the specific page from the decree addressing custody and benefit responsibilities for our records:_____

(Information regarding other coverage will be verified every 12 months)

Signature: _____ Date:

Return to:
Mail - PO Box 211034, Eagan MN 55121
Fax - 610.491.4992
E-mail - claims.hnas@hnas.com