Patient Health Plan Coverage

This form collects information about a patient's health plan coverage, including if the patient has coverage under more than one plan.

COMMUNITY HEALTH CHOICE

Patient Name	Date of Birth (DOB)
Health Care Provider Name	NPI (Provider to complete)

SECTION 1: HEALTH PLAN INFORMATION

Primary Subscriber Name	Primary Subscriber DOB	
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Member ID / Policy Number (Include letters)	Group Number	
Health Plan Name		
Health Plan Address: City	State	ZIP
Health Plan Phone Number	Coverage Start Date	Coverage End Date
Employer Name	Subscriber is: ☐ Active ☐ Retired ☐ on COBRA	
Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare		

A. Do you have coverage under another health plan?

☐ Yes, other insurance. **Go to Section 2.**

☐ Yes, Medicare. **Go to Section 3.**

☐ No other coverage. **Go to Section 4.**

SECTION 2: OTHER HEALTH PLAN INFORMATION

Primary Subscriber Name	Primary Subscriber DOB	
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____		
Member ID / Policy Number (Include letters)	Group Number	
Health Plan Name		
Health Plan Address: City	State	ZIP
Health Plan Phone Number	Coverage Start Date	Coverage End Date
Employer Name	Subscriber is: ☐ Active ☐ Retired ☐ on COBRA	
Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare		

SUBMIT COMPLETED FORM TO: cobgroup@communityhealthchoice.org

PROVIDER SERVICES PHONE: STAR CHIP: 1-888-760-2600 (TTY: 711) • **STAR PLUS:** 1-888-435-2850 (TTY: 711)
MEDICARE: 1-833-276-8306 (TTY: 711) • **MARKETPLACE:** 1-855-315-5386 (TTY: 711)

MAIL FORM TO: Attention Eligibility • Community Health Choice, Inc. • 4888 Loop Central Drive, Ste. 600 • Houston, TX 77081

Patient Health Plan Coverage

This form collects information about a patient's health plan coverage, including if the patient has coverage under more than one plan.

COMMUNITY HEALTH CHOICE

SECTION 2: OTHER HEALTH PLAN INFORMATION *CONTINUED*

A. If the patient is a child, provide:

Mother's Name	DOB
Father's Name	DOB

B. If parents are separated, divorced, or not married, list:

Child resides with	Relationship
Individual with custody	Relationship

C. Is there a court order establishing responsibility for health care coverage?

☐ No ☐ Yes

If yes, provide the following: Responsible party	Relationship

SECTION 3: MEDICARE COVERAGE INFORMATION

Medicare Subscriber Name	Medicare ID Number

☐ Part A – Effective Date ☐ Part B – Effective Date

Entitlement reason:

☐ Age

☐ Disability

☐ End Stage Renal Disease

- If due to end stage renal disease, provide the first date of dialysis
- ☐ Home Dialysis ☐ Facility or Dialysis Center
- Date of kidney transplant, if applicable

SECTION 4: SIGNATURE

Name of Person Completing the Form

Relationship to patient

Signature

Date

0060886

SUBMIT COMPLETED FORM TO: cobgroup@communityhealthchoice.org

PROVIDER SERVICES PHONE: STAR CHIP: 1-888-760-2600 (TTY: 711) • **STAR PLUS:** 1-888-435-2850 (TTY: 711)
MEDICARE: 1-833-276-8306 (TTY: 711) • **MARKETPLACE:** 1-855-315-5386 (TTY: 711)

MAIL FORM TO: Attention Eligibility • Community Health Choice, Inc. • 4888 Loop Central Drive, Ste. 600 • Houston, TX 77081