Enrollee's Other Health Plan Coverage

Instructions: Provide the coverage information for each family member covered under your health plan.

You'll need to submit to: _____

COMMUNITY HEALTH CHOICE

SECTION 1: HEALTH PLAN INFORMATION

Relationship	Name	Date of Birth (DOB)	Covered by another plan?
Self (Primary subscriber)			☐ Yes ☐ No
Spouse			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No

- If no one is covered by another plan, go to **Section 4** to sign and submit the form.
- If anyone has another plan, complete **Section 2**. Also complete **Section 3** if there's Medicare coverage.
- If there is more than one additional plan, provide the information in a separate copy.

SECTION 2: OTHER HEALTH PLAN INFORMATION

Primary Subscriber Name	Primary Subscriber DOB	
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		

List each person covered by this plan:

Spouse _____ Dependent _____

Dependent _____ Dependent _____

Dependent _____ Dependent _____

SUBMIT COMPLETED FORM TO: cobgroup@communityhealthchoice.org

MEMBER 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

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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

If multiple children have coverage under another plan — and the information above is different, provide in a separate copy.

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 Primary Subscriber

Signature

Date

0060886

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