OTHER INSURANCE QUESTIONNAIRE

Alliant Health Plans knows that sometimes you may have more than one health insurance plan covering either you or your dependents. If you do have additional health coverage, please fill out this form so that your claims will process correctly. We rely on your prompt and accurate reply. If after submission, any of the information below changes, please contact Alliant Health Plan's Client Services immediately by calling 866-403-2785. Please complete and return the requested information along with all additional documentation, via mail or fax.

Mail to: Alliant Health Plans
PO BOX 1128
Dalton, GA 30722

Fax to: 866-634-8917

SUBSCRIBER INFORMATION

Subscriber Name:	
Subscriber ID Number:	Date of Birth: MM/DD/YYYY
Claim Number (if applicable):	
Subscriber Phone Number:	Subscriber Email:

SECTION A: OTHER INSURANCE

Is the patient or any dependent(s) on this policy covered by another medical insurance policy?

☐ No Please continue to Section D.

☐ Yes Please complete all the fields below pertaining to the member(s) that has other coverage.
Please include a copy of the other insurance identification card with this form upon submission.

What type of policy is this? ☐ Group ☐ Individual ☐ Student ☐ Medicare (Continue to Section B.)

Other Instance Carrier's Name:

Address:

Phone Number:

Dependent(s) listed on the other insurance:

Other Insurance subscriber's name:

Subscriber's Date of Birth: MM/DD/YYYY	ID Number:
Effective Date of Other Insurance: MM/DD/YYYY	If canceled, cancellation date: MM/DD/YYYY

If Group plan, is the policy holder:
☐Actively working for the group ☐Inactive ☐Retired, retirement date: _____ ☐On COBRA, start date: _____

SECTION B: MEDICARE INFORMATION

Do the Alliant Health Plan subscriber and/or dependent(s) have Medicare?

☐ No Please continue to Section D.

☐ Yes Please complete all the fields below pertaining to the member(s) with Medicare. Please include a copy of the Medicare identification card with this form upon submission.

Name of person(s) with Medicare:

Medicare number, including alpha character(s):

Effective date of Medicare Part A: MM/DD/YYYY	Effective date of Medicare Part B: MM/DD/YYYY

If person has Medicare due to Disability or End Stage Renal Disease (ESRD), please supply the following information:

1st Date of Disability: MM/DD/YYYY

Was ESRD started in a facility? ☐Yes ☐No

1st Date of Dialysis of ESRD: MM/DD/YYYY

Was ESRD started as a Self-Dialysis or Home Dialysis? ☐Yes ☐No

SECTION C: COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ No Please continue to Section D.

☐ Yes Please complete all the fields below pertaining to the Court Order Information.

List the name(s) of the dependent(s) that this applies to:

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the dependent(s)?

Who has custody of the dependent(s) more than 50% of the time?

Alliant Health Plans may request documentation of the court order

SECTION D: NAME OF DEPENDENT(S) ON ALLIANT HEALTH PLANS POLICY

Name:		Relationship:
Date of Birth: MM/DD/YYYY	Gender:	Social Security Number:
Name:		Relationship:
Date of Birth: MM/DD/YYYY	Gender:	Social Security Number:
Name:		Relationship:
Date of Birth: MM/DD/YYYY	Gender:	Social Security Number:

Subscriber Signature _____ Date: MM/DD/YYYY _____