Other Health Insurance Coverage Questionnaire

Medicare requires us to verify if members have additional health insurance. This information helps us process your claims correctly. Please note:

- If you have other health insurance, include a copy of your member ID card with your completed questionnaire.
- Even if you only have coverage through Sharp Health Plan, please complete the questionnaire.
- Return your completed questionnaire using the enclosed envelope.

Please make any necessary corrections to the following information		
Member name:		Phone number:
Birth date: (MM/DD/YYYY)	Sharp Health Plan member ID#:	Employer:
Address:		
City:	State:	ZIP code:
☐ Check here if Sharp Health Plan is your only health insurance coverage.		

Other Health Insurance information	
Other insurance company name:	Effective date of other health insurance:
Type of policy: (Please check one.) ☐ Self Only ☐ Self and Family ☐ Self and Spouse ☐ Self and Children Other:_____	
Policyholder's name:	Policyholder's birth date: (MM/DD/YYYY)
Type of Coverage: (Please check one.) ☐ Medical ☐ Hospital ☐ Dental ☐ Vision ☐ Other: _____	

Please sign below	
I hereby certify that the information I have provided is true, complete and correct to the best of my knowledge.	
Signature:	Date: (MM/DD/YYYY)

Thank you for taking the time to complete this questionnaire. If you have any questions or need to update information provided previously, please call Customer Care at 1-855-562-8853 (TTY/TDD: 711).