OTHER INSURANCE CARRIER INFORMATION

Use this form to update Blue Cross Blue Shield of Arizona (BCBSAZ)

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

BCBSAZ Policy Holder Name _____

BCBSAZ Member ID (include all letters and numbers) _____

Section 1

In addition to your Blue Cross Blue Shield of Arizona (BCBSAZ) healthcare coverage, are you, your spouse, or any of your children currently covered by any other healthcare coverage or Medicare coverage?

- ☐ **No** If NO, please sign and date form.
- ☐ **Yes (other healthcare coverage)** If YES other healthcare plan, please complete section 2, sign and date form.
- ☐ **Yes (Medicare)** If YES covered by Medicare, please complete section 3, sign and date form.

Section 2 – Other Healthcare Coverage

If there is more than one source of other healthcare coverage, please attach an extra sheet with the information.

Type of Coverage

☐ **Healthcare (Medical)** ☐ **Dental** ☐ **Both**

Name of Policyholder for Other Healthcare Coverage	Relationship to BCBSAZ Policyholder	Date of Birth
		/ /

Name of Employer	Employer's Phone Number

Name of Health Plan Carrier	Carrier's Phone Number

Address of Health Plan Carrier	City	State	Zip

Other Health Plan ID Number	Group Number	Effective Date	End Date
		/ /	/ /

Please list all BCBSAZ members who are covered under this other benefit plan:

Name	Relationship to Other Policyholder	Name	Relationship to Other Policyholder
Name	Relationship to Other Policyholder	Name	Relationship to Other Policyholder
Name	Relationship to Other Policyholder	Name	Relationship to Other Policyholder

Is the other coverage for a child of the policy holder supplied because of a divorce decree or court ordered custody agreement?

☐ **Yes** ☐ **No**

If **yes**, a copy of the divorce decree or court order must be mailed along with this form. Please send only the front page with the case number and name of the parties, and all pages about the insurance coverage.

If there is **no** divorce decree or custody agreement, enter birth dates for father and mother.	Birth Date of Father (mm/dd/yyyy)	Birth Date of Mother (mm/dd/yyyy)
	/ /	/ /

Section 3 – Medicare Coverage

Name of Beneficiary	Medicare Number

Part A Hospital effective date	Part B Medical effective date
/ /	/ /

Beneficiary's Employment Status ☐ **Active** ☐ **Retired** ☐ **COBRA**

Medicare Entitlement Reason ☐ **Age 65** ☐ **Disability** ☐ **End-Stage Renal Disease (ESRD)**

Authorized [Electronic] Signature (BCBSAZ Policy Holder)

I am _____, and I verify that the above information is current and accurate. I agree that by entering my name in the electronic signature field below, I am verifying the information as provided.

/s/_____ _____

Authorized [Electronic] Signature Date

Update Blue Cross Blue Shield of Arizona with your coverage information using only ONE of the following options:

☐ **Fax the form to BCBSAZ**

Complete, sign, save, and fax the form along with any required documentation to BCBSAZ at: **602-864-4385**.

Note: BCBSAZ members with State of Arizona (ADOA) benefit plans, fax to: **602-542-4744**.

☐ **Mail the form to BCBSAZ**

Complete, sign, save, print, and mail the form along with any required documentation to the address on the back of your member ID card.

☐ **Call BCBSAZ customer service at 602-864-4465**.

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