OTHER INSURANCE COVERAGE

For members with Medicare Advantage plans
Use this form to update Blue Cross Blue Shield of Arizona

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Thank you for being a Blue Cross® Blue Shield® of Arizona (BCBSAZ) Medicare Advantage member. To correctly process your claims, we need to know if you have any other medical or prescription drug coverage so that we can coordinate benefits on your behalf. Please fill out the applicable information and then sign, save, and email your completed form to BCBSAZ at **ContactAdvantage@azblue.com** or mail it to

Blue Cross Blue Shield of Arizona
PO Box 2923
Phoenix, AZ 85038

If you have any questions, we are happy to help. Please call Member Services at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331. TTY users should call 711. We are available from 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 to September 30; and 7 days a week from October 1 to March 31.

Si tiene alguna pregunta, comuníquese con nosotros al 480-937-0409 (en Arizona) o al número gratuito 1-800-446-8331. Los usuarios de TTY deben llamar al 711. Estamos disponibles de 8:00 a.m. a 8:00 p.m., lunes a viernes desde el 1 de abril hasta el 30 de septiembre; y los 7 días de la semana desde el 1 de octubre hasta el 31 de marzo.

QUESTIONNAIRE

Member Name: _____ Member ID #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Do you have coverage under any other <u>medical</u> plan?

☐ **No** If *No,* please complete Section A and sign the form in Section E.

☐ **Yes** If *Yes,* please complete all fields in Section B that pertain to your other medical insurance coverage and sign the form in Section E.

Section A

☐ I have no other medical insurance coverage.

Section B

Policy Holder's Name: _____

Policy Number: _____

Employer's Name: _____

Insurance Name: _____

Insurance Address: _____

Insurance Carrier's Phone: _____

Effective date: _____ Termination date: _____

Do you have coverage under any other prescription plan?

☐ **No** If *No,* please complete Section C and sign the form in Section E.

☐ **Yes** If *Yes,* please complete all fields in Section D that pertain to your other prescription coverage and sign the form in Section E.

Section C

☐ I have no other prescription insurance coverage.

Section D

Policy Holder's Name: _____

Policy Number: _____

Employer's Name: _____

Insurance Name: _____

Insurance Address: _____

Insurance Carrier's Phone: _____

Insurance RX ID #:: _____

RX Group Number: _____

RX BIN Number: _____

RX PCN Number: _____

Effective date: _____ Termination date: _____

Section E

Authorized Electronic Signature

I am _____, and I agree that by entering my signature in the electronic signature field below, I am verifying my intention to sign this form and verifying the accuracy of the information provided in this form.

/s/ _____ Date: _____

Authorized [Electronic] Member Signature

Please fill out the applicable information and then sign, save, and email your completed form to BCBSAZ at **ContactAdvantage@azblue.com** or mail it to

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