WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

Coverage for Dependent Children Questionnaire Form

CIGNA HealthCare

The patient will enter the Subscriber's Name, Subscriber's Address, Their relationship to the patient, Cigna healthcare group number and member ID number.

, please complete this form.

viding the child's medical coverage, unless legally health benefits and make sure you receive prompt, e the information we've requested.

Please return this completed questionnaire form to the CIGNA HealthCare Claims Center listed on your CIGNA HealthCare ID card. If you have any questions or need assistance in completing this form, simply call the Claims Center and a representative will be happy to help you.

Please fill out form completely. **Please note: This form cannot be submitted online.** After filling in all of the fields, please print this form by clicking the button at the end of this form or by using your web browser's print function and mail it to the CIGNA HealthCare claims center listed on the back of your CIGNA H[illegible]are ID Card.

EMPLOYEE ENROLLED IN A CIGNA HEALTHCARE PLAN:

EMPLOYEE ADDRESS: *(Street)* *(Apt. #)* *(City)* *(State)* *(Zip Code)*

RELATIONSHIP: ☐ Self ☐ Spouse	CIGNA HEALTHCARE GROUP NUMBER:	CIGNA HEALTHCARE MEMBER ID NUMBER:

PLEASE PROVIDE THE FIRST AND LAST NAMES OF ALL DEPENDENT CHILDREN:

1.
2.
3.

The Subscriber will input all listed dependents on the Health Insurance.

WHO HAS LEGAL CUSTODY OF THE ABOVE NAMED DEPENDENT(S)?

DO ANY DEPENDENT CHILDREN LIVE WITH YOU? ☐ Yes ☐ No

IF NO, PLEASE PROVIDE THE NAME, DATE OF BIRTH AND ADDRESS OF THE PARENT/GUARDIA[illegible] WITH WHOM THE DEPENDENT(S) LIVE(S):

Parent/Guardian Name: *Date of Birth:*

Address:

IS THE PARENT WHO DOES **NOT** HAVE LEGAL CUSTODY RE[illegible]IRED BY COU[illegible] CHILD(REN)'S HEALTH CARE EXPENSES? ☐ Yes ☐ No

IF A COURT ORDER ASSIGNS FINANCIAL RESPONSIBILITY TO ONE PARENT [illegible] THE ORDER.

PLEASE PROVIDE THE NAME AND SOCIAL SECURITY NUMBER OF TH[illegible]E

Name:

The patient MUST select YES or NO for EACH of the following.

IF the dependent does not live with the subscriber, the subscriber must input the other biological parent's information

IS THE HEALTH CARE COVERAGE THROUGH AN EMPLOYER? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE THE EMPLOYER'S NAME AND ADDRESS:

Employer Name:

Address:

PLEASE PROVIDE THE NAME, POLICY NUMBER AND ADDRESS [illegible]

Carrier:

Address:

The individual completing the form must sign and date. Please note, if the form is not completed accurately the form will be deemed Invalid

SIGNATURE:	DATE SIGNED:

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Spousal Coverage Questionnaire Form

CIGNA HealthCare

The patient will enter the Subscriber's Name, Subscriber's Address, Their relationship to the patient, Cigna healthcare group number and member ID number. The spousal information and the spouse employment status.

…omplete this form.

…make sure you receive prompt, fair and accurate …n we've requested.

…**aims Center listed on your CIGNA HealthCare ID card.** If you have any questions or need assistance in completing this form, simply call the Claims Center and a representative will be happy to help you.

Please fill out form completely. **Please note: This form cannot be submitted online.** After filling in all of the fields, please print this …HealthCare claims center listed on the back of your CIGNA HealthCare ID Card.

EMPLOYEE ENROLLED IN A CIGNA HEALTHCARE PLAN:

EMPLOYEE ADDRESS: *(Street)* *(Apt. #)* *(City)* *(State)* *(Zip Code)*

RELATIONSHIP: ☐ Self ☐ Spouse | CIGNA HEALTHCARE GROUP NUMBER: | CIGNA HEALTHCARE MEMBER ID NUMBER:

SPOUSE'S NAME: | SPOUSE'S DATE OF BIRTH: | SPOUSE'S SOCIAL SECURITY NUMBER:

…

IF YES, PLEASE PROVIDE THE EMPLOYER'S NAME AND ADDRESS:

Employer Name:

Address:

IF yes, the subscriber will input the spouse's employer information.

DOES YOUR SPOUSE PARTICIPATE IN A HEALTH BENEFITS PLAN OFFERED BY THIS EMP…OYER? ☐ Yes ☐ No

IF YES, WHAT'S THE HEALTH CARE CARRIER'S NAME, ADDRESS AND POL…

Carrier:

Address:

The patient MUST select YES or NO for EACH of the following.

IS THIS GROUP COVERAGE? ☐ Yes ☐ No

WHEN DID YOUR SPOUSE'S COVERAGE BECOME EFFECTIVE? | WHEN DOES THIS COVERAGE PERIOD EXPIRE?

DOES YOUR SP…E'S COVERAGE EXTEND TO DEPENDENT CHILDREN? ☐ Yes ☐ No

IS YOUR SPOUSE RETIRED? ☐ Yes ☐ No | IF YES, WHAT IS THE DATE OF YOUR SPOUSE'S RETIREMENT?

ARE YOU COVERED BY MEDICARE? ☐ Yes ☐ No | IF YES, YOUR ME…

IS YOUR SPOUSE COVERED BY MEDICARE? ☐ Yes ☐ No | IF YES, YOUR SP…

WHO IS COVERED UNDER MEDICARE PART A? ☐ Self ☐ Spouse | WHO IS COVERED UNDER MEDICARE PART B? ☐ Self ☐ Spouse

ARE YOU OR YOUR SPOUSE COVERED UNDER MEDICARE BECAUSE OF KIDNEY FAILURE? ☐ Yes: ☐ Self ☐ Spouse ☐ No | WHEN DID KIDNEY DIALYSIS BE…

The individual completing the form must sign and date. Please note, if the form is not completed accurately the form will be deemed Invalid

SIGNATURE: | DATE SIGNED: