WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

The Patient will enter the Subscriber's name and Address.

EmblemHealth

OTHER HEALTH INSURANCE QUESTIONNAIRE

Send completed form to: EmblemHealth HMO, PO Box 9091, COB Unit, Melville, NY 11747-9890
EmblemHealth PPO, PO Box 2804, New York NY 10116-2804

SECTION A - SUBSCRIBER INFORMATION

SUBSCRIBER NAME: LAST FIRST MI

SUBSCRIBER ADDRESS:

CITY: STATE: ZIP:

INSURANCE ID #:

DATE OF BIRTH: ___/___/___ SEX: ☐ MALE ☐ FEMALE MARITAL STATUS:

EMPLOYER NAME

EMPLOYER ADDRESS:

Number of persons working for your employer:

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO

ARE YOU CURRENTLY RETIRED? ☐ YES ☐ NO

If retired, please give date of retirement: ___/___/___

Are you covered under any other insurance plan? ☐ YES (Please complete section B, C and D) ☐ NO (Please complete section B)

(Including Medicare, Medicaid, Workers Compensation, No-Fault, TRICARE, COBRA, other group health plan, Black Lung, federal, state or local governme

SECTION B - SPOUSE INFORMATION

SPOUSE'S NAME: (Last, First, MI)

SPOUSE'S SOCIAL SECURITY NUMBER: SPOUSE'S SEX:

SPOUSE'S DATE OF BIRTH (MM/DD/YY):

___/___/___

Is your spouse covered under any other insurance plan? ☐ YES (Please complete section C) ☐ NO

(Including Medicare, Medicaid, Workers Compensation, No-Fault, TRICARE, COBRA, other group health plan, Black Lung, federal, state or local government plan)

The patient will enter Subscriber's Date of Birth, Member ID (Identification Number), Patient's Marital Status, Employer name and Address.

SECTION C - OTHER INSURANCE COVERAGE

Please complete this section if any me

If the Patient is covered under their Spouse, Section "B" will require the Spousal information to be filled out.

NAME OF PERSON WHO IS THE SUBSCRIBER O

INSURANCE COMPANY NAME:

EFFECTIVE DATE: ___/___/___

CONTRACT TYPE:

☐ INDIVIDUAL ☐ FAMILY ☐ PARENT/CHILD ☐ SUBSCRIBER/SPOUSE

If applicable, please attach a copy of any court order for dependent health coverage.

NAME AND ADDRESS OF PLAN PROVIDING THE OTHER COVERAGE:

Check all that apply:

☐ MEDICAL ☐ HOSPITAL ☐ DENTAL ☐ PRESCRIPTION ☐ NO FAULT

☐ WORKERS COMPENSATION Date of Accident/Injury: ___/___/___

SECTION D - MEDICARE COVERAGE

ARE YOU OR ANY OF YOUR FAMILY COVERED BY MEDICARE?

☐ YES ☐ NO

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

SUBSCRIBER'S INFORMATION

MEDICARE NUMBER:

MEDICARE NUMBER:

EFFECTIVE DATE PART A ___/___/___ EFFECTIVE DATE PART B ___/___/___

EFFECTIVE DATE PART A ___/___/___ EFFECTIVE DATE PART B ___/___/___

SECTION E - CERTIFICATION

I certify that the information given is correct and that benefits are not available under any other Group Plan except as indicated where applicable in Section C and Section D of this form. Any person who knowingly and with intent to defraud any Insurance Company or any other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a Civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE: DATE SIGNED: