

Your QualChoice contract may contain a Coordination of Benefits (COB) provision. We depend on your help to process your claims correctly. We appreciate your prompt and accurate reply. Please return the questionnaire within 30 calendar days.

Section I: Subscriber Information								
Name of QualChoice Subscriber (Last, First, Middle Initial)				QualChoice ID No.		Contact Phone No.		
Are you, or any member of your family who are covered by QualChoice, also covered by another group health plan or Medicare? <input type="checkbox"/> Yes. If Yes, complete Section II (if another group health plan), or Section III (if Medicare). <input type="checkbox"/> No. If No, please sign below and return this form to us.								
Section II: Other Group Health Plan. <i>Please attach a copy of the insurance ID card.</i>								
Group Health Plan Name				Policy or Group No.				
Address			City			State	Zip	
Name of Policyholder		Date of Birth (MM/DD/YYYY)		Effective Date of Coverage		If cancelled, give date.		
<i>List all family members (include yourself) covered by this group health plan, their relationship to you (the Subscriber), and the parent responsible for coverage. If there is a court order for dependent coverage, send a copy of the order.</i>								
Name		Relationship	Parent Responsible for Coverage			Is there a court order?		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
Section III. Medicare Information. <i>Please attach a copy of the Medicare ID card.</i>								
Are you actively/presently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No								
List all family members (include yourself) also covered by Medicare.								
Name		Medicare ID No.	Medicare eligibility due to:			Effective Date		
			Age 65+	Disability	Renal Disease	Part A	Part B	Part C
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Section IV: Authorized Signature								
I understand and agree that any omissions or false information knowingly given by myself and/or my eligible dependents on this form may cancel coverage for me and/or my covered dependents.								
Subscriber's Signature					Date (MM/DD/YYYY)			
Section V: Instructions								
You can return this form to us by fax or mail. Be sure to include all requested items. QualChoice Attn: Claims Department P.O. Box 25610 • Little Rock, AR 72221 Fax: 501.228.0135				IMPORTANT <i>Failure to respond within 30 calendar days will result in claims being pended/denied until this questionnaire is returned.</i>				