TDI | Texas Department of Insurance

LHLXXX | 0625

# Health Coverage Questionnaire

| Patient or member name | Date of birth | Health care provider |
|---|---|---|

## Section 1: Provide information about your health plan

| Primary subscriber name | Health plan name |
|---|---|
| Primary subscriber date of birth | Health plan address |
| Member ID or policy number | City / State / ZIP code |
| Group number or employer name | Health plan phone number |
| Coverage start date / Coverage end date | Relationship of patient to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other |
| Subscriber is: ☐ Active ☐ Retired ☐ On COBRA | Plan is: ☐ Group ☐ Individual ☐ Supplemental |

### Do you have coverage under another health plan?

- ☐ Yes, other insurance. Go to **Section 2**
- ☐ Yes, Medicare. Go to **Section 3**
- ☐ No other coverage. Go to **Section 4**

## Section 2: Provide information about your other health plan

| Primary subscriber name | Health plan name |
|---|---|
| Primary subscriber date of birth | Health plan address |
| Member ID or policy number | City / State / ZIP code |

| Group number or employer name | Health plan phone number |
|---|---|
| | |

| Coverage start date | Coverage end date | Relationship of patient to subscriber |
|---|---|---|
| | | ☐ Self ☐ Spouse ☐ Child ☐ Other |
| Subscriber is: | | Plan is: |
| ☐ Active ☐ Retired ☐ On COBRA | | ☐ Group ☐ Individual ☐ Supplemental |

## Section 2a: If the patient is a child, please provide:

| Mother's name | Date of birth | Father's name | Date of birth |
|---|---|---|---|
| | | | |

## Section 2b: If parents are separated or divorced:

| Child resides with | Relationship | Is there a court order establishing responsibility for health care coverage? | |
|---|---|---|---|
| | | Yes ☐ No ☐ | |
| Individual with custody | Relationship | Responsible party | Relationship |
| | | | |

## Section 3: Provide information about your Medicare coverage

| Medicare ID number | | If covered due to end stage renal disease: | |
|---|---|---|---|
| ☐ | Part A - Effective date | First date of dialysis | |
| ☐ | Part B - Effective date | ☐ Home dialysis ☐ Facility or dialysis center | |
| Entitlement reason | | Date of kidney transplant, if applicable | |
| ☐ Age ☐ Disability ☐ End stage renal disease | | | |

## Section 4: Signature

| Name of person completing the form | Signature | Date |
|---|---|---|
| | | |

# Other Health Coverage Questionnaire

Include coverage information for each family member who is covered under your [Health plan name] health plan.

## Section 1: Provide information about you and your family's coverage

| Relationship | Name | Date of birth | Covered by another plan? |
|---|---|---|---|
| Primary subscriber | | | ☐ Yes ☐ No |
| Spouse | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |
| Dependent | | | ☐ Yes ☐ No |

- If no members have other coverage, go to Section 4 to sign and submit the form.
- If one or more members have other coverage, complete Section 2 for other health insurance and Section 3 for Medicare coverage, as applicable.

## Section 2: Provide information about your other health plan

| Primary subscriber name | Health plan name | | |
|---|---|---|---|
| | | | |
| Primary subscriber date of birth | Health plan address | | |
| | | | |
| Member ID or policy number | City | State | ZIP code |
| | | | |
| Group number or employer name | Health plan phone number | | |
| | | | |
| Coverage start date Coverage end date | Subscriber is: | | |
| | ☐ Active ☐ Retired ☐ On COBRA | | |

| List each person covered by this plan: | | Plan is: | |
|---|---|---|---|
| Spouse | | ☐ Group ☐ Individual ☐ Supplemental | |
| Dependent | | Dependent | |
| Dependent | | Dependent | |
| Dependent | | Dependent | |

## Section 2a: If the other plan covers a child, please provide:

| Mother's name | Date of birth | Father's name | Date of birth |
|---|---|---|---|
| | | | |

## Section 2b: If parents are separated or divorced:

| Child resides with | Relationship | Is there a court order establishing responsibility for health care coverage? | |
|---|---|---|---|
| | | Yes ☐ No ☐ | |
| Individual with custody | Relationship | Responsible party | Relationship |
| | | | |

If multiple children have coverage under another plan and the information above is different, provide the additional information in a separate form.

## Section 3: Provide information about your Medicare coverage

| Member name | | | |
|---|---|---|---|
| Medicare ID number | | If covered due to end stage renal disease: | |
| ☐ Part A - Effective date | | First date of dialysis: | |
| ☐ Part B - Effective date | | ☐ Home dialysis ☐ Facility or dialysis center | |
| Entitlement reason | | Date of kidney transplant, if applicable: | |
| ☐ Age ☐ Disability ☐ End stage renal disease | | | |

## Section 4: Signature

| Name of person completing the form | Signature | Date |
|---|---|---|
| | | |

## Instructions for submitting the form

[Health plan can provide instructions for how and where members can submit the form.]