

# Duplicate Coverage Questions

For Other Party Liability



Section 1

Member Name     
Last First MI

Member's ID No.

Home Address      
Street City State Zip Code

Home Phone No.    Cell Phone No.     
Area code Area code

Change of Address (If the address above is a different address, please check this box).

This is a routine periodic inquiry. The information you provide will allow us to update your file, which will help prevent processing delays and ensure more accurate claims payments.

1. Are you, your spouse, or your covered dependent children enrolled in other GROUP health insurance (NOT Medicare, SRS/Medicaid)?  Yes  No (If "Yes" complete all remaining questions below.)

2. Name of other insurance company

Address of other insurance company   
Street

City State Zip Code

Phone number of other insurance company     
Area Code

Section 2

3. Name of policyholder     
Last First MI

Date of birth of policyholder  /  /   
MM DD YYYY

4. Identification number through which policy is provided

Group number through which policy is provided

5. Employer or group through which the policy is provided

6. Address of employer   
Street

City State Zip Code

Phone number of employer     
Area Code

**NOTE: If any information above is unknown, contact the employer or group named in question 5 for assistance. Blue Cross and Blue Shield of Kansas cannot extend benefits without evidence of other insurance payment when the other insurance is the primary carrier. Please submit an Explanation of Benefits from the other insurance company.**

**Your signature required**

Date  /  /   
MM DD YYYY

Section 3

**Questions?** Please contact Other Party Liability at:

Toll Free: (800) 430-1274

(785) 291-4013 option 5

Fax: (785) 291-8981

Or by mail at:

1133 SW Topeka Boulevard

Maildrop 217D5

Topeka, KS 66629-0001

Or online at:

[www.bcbsks.com](http://www.bcbsks.com)