

Duplicate Coverage Questions

for Other Party Liability (to be completed by Member)



Section 1 – Member Information

First Name _____ MI _____ (____) ____ - ____ Home Phone Number (____) ____ - ____ Cell Phone Number

Last Name _____ Member ID Number _____

Home Address _____ Change of address: If the address you listed is a different address, please check this box.

City _____

State _____ ZIP Code _____ +4 _____

Section 2 – Other Coverage Information

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.

Are you, your spouse or your covered dependent children enrolled in other insurance (medical, dental, vision or prescription – NOT Medicare, SRS/Medicaid)?

Yes No

If you answered Yes, please complete all remaining questions in this section.

Name of Other Insurance Company _____

Address of Other Insurance Company _____

City _____

State _____ ZIP Code _____

Policyholder First Name _____ MI _____

Policyholder Last Name _____

____ / ____ / ____ Policyholder Date of Birth

Identification Number through which the policy is provided _____

If your current insurance is through an employer or group, complete the following:

Group Number through which the policy is provided _____

Employer or Group through which the policy is provided _____

Address of Employer or Group _____

City _____

State _____ ZIP Code _____ (____) ____ - ____ Employer Phone Number

IMPORTANT: If any information above is unknown, contact the employer or group named above 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.

Section 3 – Authorization

Your signature required

Applicant _____ Date Signed ____ / ____ / ____

Questions? Please contact Other Party Liability at:

Toll Free: (800) 430-1274 or in Topeka, (785) 291-4013

Fax: (785) 290-0771

Online: bcbsks.com

By mail at: 1133 SW Topeka Blvd.
Mailstop 259C2
Topeka, KS 66629-0001

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001, 1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید..