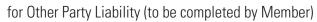
Duplicate Coverage Questions





| Section 1 – Member Information | |
|---|--|
| First Name MI | (|
| 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 proprevent processing delays and ensure more accurate claim | , |
| 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 your current insurance is through an employer or group, complete the following: Group Number through which the policy is provided |
| If you answered Yes, please complete all remaining questions in this section. | Employer or Group through which the policy is provided |
| Name of Other Insurance Company Address of Other Insurance Company | Address of Employer or Group City |
| City | State ZIP Code () Employer Phone Number |
| State ZIP Code | IMPORTANT: If any information above is unknown, contact the employer or group named above for assistance. Blue Cross and Blue Shield of Kansas |
| Policyholder First Name MI Policyholder Last Name | cannot extend benefits without evidence of other insurance payment when the other insurance is the primary carrier. Please submit an Explanation of Benefits |
| Policyholder Date of Birth | from the other insurance company. |
| Identification Number through which the policy is provided | |
| Section 3 – Authorization | |
| Your signature required Applicant | |
| 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 217C2

Topeka, KS 66629-0001

By email at: OPL@bcbsks.com