



Date

Name  
Address  
Address

Group Name  
ID#

Re: Other Insurance

Preferred Health Plan of the Carolinas is trying to determine if the below member (s) has additional insurance.

Does the member, \*name\*, have other coverage? **Yes** or **No** (circle one)

If you answered **Yes**, please complete the following questions to prevent delay of claims processing if there is other insurance:

- 1. Name and address of employer(s):

\_\_\_\_\_

\_\_\_\_\_

- 2. Name, address and phone number of insurance carrier (**please include supplemental coverage, Medicaid, Medicare or Tricare**):

\_\_\_\_\_

\_\_\_\_\_

- 3. Policy number: \_\_\_\_\_

- 4. List all dependents covered by this policy.

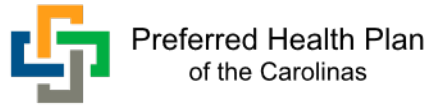
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Member  
Signature \_\_\_\_\_

Thank you for your assistance,



Claims

Preferred Health Plan of the Carolinas  
PO Box 749  
Matthews, NC 28106