Preferred Health Plan
of the Carolinas

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,

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

Preferred Health Plan
of the Carolinas

Claims

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