SEND COMPLETED FORM TO: County Medical Services Program, Attn. TPL Unit, 1545 River Park Drive, Suite 435, Sacramento, CA 95815

CMSP/OTHER HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. **Attach a copy of your insurance policy, membership card or any other documents to help complete this questionnaire.** PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. FAILURE TO REPORT OTHER HEALTH INSURANCE MAY CAUSE OVERPAYMENT OR TERMINATION OF YOUR CMSP ELIGIBILITY.

Case number:	CIN:

Section I: Please list the name of the person covered by other health insurance

Name (first, middle, last)	Date of Birth	Social Security Number	Sex

Section II: Health Insurance Information (Insurance 1) **Health Insurance Information (Insurance 2)**

Health Insurance Information (Insurance 1)	Health Insurance Information (Insurance 2)
1. What is the name and address of your health insurance company? Include street number, city, state and ZIP. Do not use abbreviations. Company Name:_____ Address: _____ City, State, Zip: _____	1. What is the name and address of your health insurance company? Include street number, city, state and ZIP. Do not use abbreviations. Company Name: _____ Address: _____ City, State, Zip: _____
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☐ Yes ☐ No	2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☐ Yes ☐ No
3. What is the full name, address, phone number, and Insurance Identification Number of the individual, employee, union member, or person to whom the insurance policy was issued? Spouse? ☐ Yes ☐ No Insured Name:_____ Insurance ID Number: _____ Address: _____ Telephone number: (_____)_____ City, State, ZIP: _____	3. What is the full name, address, phone number, and Insurance Identification Number of the individual, employee, union member, or person to whom the insurance policy was issued? Spouse? ☐ Yes ☐ No Insured Name:_____ Insurance ID Number: _____ Address: _____ Telephone number: (_____)_____ City, State, ZIP: _____
4. What is the policy number? 5. What are the dates of your policy? Beginning date: Ending date(if applicable):	4. What is the policy number? 5. What are the dates of your policy? Beginning date: Ending date(if applicable):
6. Give name, address, and telephone number of union, employer, group, organization, or school that your insurance policy is through. Group Name: _____ Local or group number: _____ Address: _____ Telephone number: (_____)_____ City, State, ZIP: _____	6. Give name, address, and telephone number of union, employer, group, organization, or school that your insurance policy is through. Group Name: _____ Local or group number: _____ Address: _____ Telephone number: (_____)_____ City, State, ZIP: _____
7. Does your health insurance provide or pay for: (Check all that apply) ☐ Hospital outpatient (i.e. lab work/physical therapy) ☐ Prescription drugs ☐ Long-term care/nursing home ☐ Hospital stays ☐ Doctor visits ☐ Dental care ☐ Only specific illness (i.e. cancer) ◆ Type of illness: _____	7. Does your health insurance provide or pay for: (Check all that apply) ☐ Hospital outpatient (i.e. lab work/physical therapy) ☐ Prescription drugs ☐ Long-term care/nursing home ☐ Hospital stays ☐ Doctor visits ☐ Dental care ☐ Only specific illness (i.e. cancer) ◆ Type of illness: _____

Section III: Signature

Signature of applicant:	Home telephone number:	Date:
Signature of person helping the applicant:	Home telephone number:	Date:

The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the CMSP. This information will be used by the County Department to establish initial and ongoing CMSP eligibility; by the CMSP's fiscal intermediary for claims processing purposes; by the CMSP Governing Board, Advanced Medical Management, and MedImpact for benefit administration and claims payment, health insurance identifications and overpayment recovery actions.