MotivHealth
PO Box 709718
Sandy, UT 84070-9718
Phone: 844-234-4472

Other Coverage Questionnaire

Date:
Name:
Address:
City, ST:

Hello,

To prevent delays in processing your claims, you'll find a short form in this letter requesting information about insurance coverage for yourself and your family. Your response is required before any future claims processing, even if you do not have any additional insurance coverage.

Please take a moment to complete the form and return it. You can mail the form to P.O. Box 709718 Sandy, UT. 84070, fax the form to us at **1-844-533-1289**, or email the form to **COB@motivhealth.com.** To simplify the email process, you can access the form online at **www.motivhealth.com/forms-documents** under "Legal and Policy" then "COB Form."

Your rapid response will be greatly appreciated and will enable us to process your claims in a timely fashion. Failure to respond may delay claims processing at the time the claims are received. Thank you for your assistance.

If you have any questions regarding this request, please contact our Personal Health Assistants at **1-844-234-4472**.

Sincerely,

MotivHealth Insurance Company

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Date:
Member ID:
Member Name:
Patient Name:

Other Insurance Information

Are you or any member of this MotivHealth plan covered by any other health insurance benefit(s), including: medical, dental, vision, or Medicare?

☐ **No** – If no, please complete the final section of this form, indicating that you have "No other insurance."

☐ **Yes** – If yes, please complete the section that pertains to the member(s) that has other insurance coverage.

Employee

Name of other insurance: _____
Address: _____
Phone: _____ Group #: _____ Policy #: _____
Effective Date: _____ Term Date: _____
Type of coverage:
☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy ☐ Disability ☐ Life

Policy Holder: _____ Date of Birth: _____

Who else is covered under this policy?

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Spouse/Dependents

Name of Other Insurance: _____
Address: _____
Phone: _____ Group #: _____ Policy #: _____
Effective Date: _____ Term Date: _____
Type of coverage:
☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy ☐ Disability ☐ Life

Policy Holder: _____ Date of Birth: _____

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Date:
Member ID:
Member Name:
Patient Name:

Spouse/Dependents, cont'd:

Who else is covered under this policy?

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Medicare information

Do you or any other family member have Medicare? ☐ Yes* ☐ No

***If yes, please submit a copy of your Medicare Card.**

***If yes, please complete the following:**

Employee

Do you have Medicare Part D, prescription coverage? ☐ Yes ☐ No

If on Medicare Disability, was disability for End Stage Renal Disease? ☐ Yes ☐ No

If ESRD, when did dialysis treatments begin? _____

Spouse/Dependents

Do you have Medicare Part D, prescription coverage? ☐ Yes ☐ No

If on Medicare Disability, was disability for End Stage Renal Disease? ☐ Yes ☐ No

If ESRD, when did dialysis treatments begin? _____

If Separated or Divorced

Complete the following for dependent children to determine which coverage has primary liability:

What was the date of divorce or separation? _____

Which parent has physical custody of the child?

Name: _____ Date of Birth: _____

Is there a court order making one parent responsible for the child's medical/dental/vision expenses?

☐ Yes* ☐ No

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***If yes, please provide a copy of the divorce decree or parenting plan**

Has the parent with custody remarried? ☐ Yes ☐ No
If yes, does the stepparent cover this child? ☐ Yes ☐ No

If Separated or Divorced, cont'd

Name of Other Insurance: _____
Address: _____
Phone: _____ Group #: _____ Policy #: _____
Effective Date: _____ Term Date: _____
Type of coverage:
☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy ☐ Disability ☐ Life

Policy Holder: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Please provide a telephone number where we may reach you if additional information is needed:

_____

I certify that the above information is true to the best of my knowledge. I authorize any physician, facility, insurance company, or employer to release information to the Plan Supervisor/Claims Processor.

_____ _____
Signature of the Employee Date

_____ _____
Signature of Dependent (if 18 years of age) Date

_____
Printed Name of Person Signing Form

Some states require that we notify you, "Any person who knowingly with intent to defraud, or deceive an insurance company or employee benefit plan, files a false statement containing false, incomplete or misleading information, is, in some states, guilty of a felony of third degree."

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This Notice is Being Provided as Required by the Affordable Care Act

Translation Services

Kung ikaw, o isang taong tinutulungan ninyo, may mga tanong tungkol sa mga kompanya ng seguro sa kalusugan ng HSA, mayroon kang ang karapatan sa tulong at impormasyon sa iyong wika nang libre. Makipag-usap sa isang interpreter, mangyaring tawagan

如果你或你正在帮助的人, 有关于 hsa 健康保险公司的问题, 你有权在你的语言中免费提供帮助和信息。与译员交谈, 请致电

Hvis du, eller nogen, du hjælper, har spørgsmål om HSA sygeforsikringsselskab, har du ret til hjælp og oplysninger på dit sprog uden omkostninger. For at tale med en tolk, ring venligst

Kung ikaw, o isang taong tinutulungan ninyo, may mga tanong tungkol sa mga kompanya ng seguro sa kalusugan ng HSA, mayroon kang ang karapatan sa tulong at impormasyon sa iyong wika nang libre. Makipag-usap sa isang interpreter, mangyaring tawagan

Si vous, ou quelqu'un que vous l'aidez, se pose des questions sur la compagnie d'assurance HSA, vous avez droit à l'aide et des renseignements dans votre langue sans frais. Pour parler avec un interprète, s'il vous plaît appelez

Wenn Sie oder jemand, den Sie eine Verbindung herstellen, Fragen über HSA Krankenkasse hat, haben Sie das Recht auf Hilfe und Informationen in Ihrer Sprache ohne Kosten. Um mit einem Dolmetscher sprechen, rufen Sie bitte

Αν εσείς ή κάποιος που βοηθάτε, έχει απορίες σχετικά με την εταιρεία ασφάλισης υγείας HSA, έχετε το δικαίωμα να βοηθήσει και τις πληροφορίες στη γλώσσα σας χωρίς κανένα κόστος. Για να μιλήσετε με έναν διερμηνέα, παρακαλώ καλέστε

Se voi, o qualcuno che stai aiutando, ha domande sulla compagnia di assicurazione sanitaria HSA, avete il diritto di aiuto e informazioni nella tua lingua senza alcun costo. Per parlare con un interprete, si prega di chiamare

あなた、またはあなたが助けている人は、hsa 健康保険会社についての質問を持っている場合、あなたは無償であなたの言語でヘルプと情報を提供する権利を持っています。通訳と話をするには、電話してください

당신이, 또는 누군가가 당신이 돕고, HSA 건강 보험 회사에 대 한 질문은, 당신이 있다면 있도록 권리 및 정보 비용 없이 귀하의 언어로. 통역사와 이야기, 전화 주세요

اگر شما یا کسی که در حال کمک به پرسشهای HSA تجم صحبت لطفا ل. تماس با م زینه هر بدون هیچ خود زبان در اطلاعات و کمک حق شما ،بیمه شکت ل

Jeśli ty lub ktoś, którym pomagasz, ma pytania o ubezpieczenie zdrowotne HSA, masz prawo do pomocy i informacji w swoim języku, bez żadnych kosztów. Aby porozmawiać z tłumacza, prosimy o kontakt

Se você, ou alguém que está ajudando, tem perguntas sobre a companhia de seguros de saúde de HSA, você tem o direito de ajuda e informações no seu idioma sem nenhum custo. Para falar com um intérprete, por favor, ligue

Если вы, или кто-то вы помогаете, есть вопросы о HSA медицинского страхования компании, у вас есть право на помощь и информацию на вашем языке на никакой цене. Чтобы поговорить с переводчиком, пожалуйста, позвоните

Si usted o alguien que está ayudando, tiene preguntas sobre la compañía de seguro médico de la HSA, usted tiene el derecho a la ayuda e información en su idioma sin costo. Para hablar con un intérprete, llame al

Om du eller någon du hjälper, har frågor om HSA sjukförsäkringföretaget, har du rätt till hjälp och information i ditt språk utan kostnad. För att prata med en tolk, ring ถา้ คณุ หรอืคนทีคณุ ชว่ยเหลอื มคีาถามเกี ยวกบั บรษิ ทั ประกนั HSA คณุไดต้ อ้ งชว่ ยและขอ้ มูลในภาษาของคณุมคี า่ ใชจ้ า่ ย โทรคุยกบั ลา่ ม

Якщо ви чи хтось вам допомогу, питання про HSA медичної страхової компанії, у вас право на допомогти і інформації на вашій мові, на безоплатній основі. Поговорити з усним перекладачем, будь ласка, зателефонуйте

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có câu hỏi về công ty bảo hiểm sức khỏe HSA, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn không tính phí. Để nói chuyện với một thông dịch viên, xin vui lòng gọi

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Non-Discrimination Notices

MotivHealth does not discriminate based on race, color, national origin, sex, age, or disability in its health programs and activities.

MotivHealth provides appropriate auxiliary aids and services, including qualified interpreters for individual with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individual with disabilities.

MotivHealth provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

To obtain the interpretations services listed in paragraphs two (2) and three (3), Participants may call 844-234-4472 and request interpretive services. For assistance in Spanish please call 1-888-346-3162. For Telecommunications Device for the Deaf please call 1-888-346-5822.

Participants have the right to file a grievance regarding potential discrimination. To file a grievance, please call MotivHealth at 844-234-4472 or mail a letter describing the grievance to PO Box 709718 Sandy, UT 84070-9718.

If a Participant believes they have been discriminated against because of their race, color, national origin, disability, age, sex or religion, the Participant by file a discrimination complaint with the Office of Civil Rights. Please visit www.hhs.gov/ocr for directions to file a complaint.