IPMG
INSURANCE PROGRAM MANAGERS GROUP

EMPLOYEE BENEFITS SERVICES

Important Requests for Information

Patient Name:_____
Covered Employee:_____
ID Number:_____
Group:_____
Service Date(s):_____
Provider:_____

Date:_____

Covered Employee:_____

Group Name:_____

This plan contains a coordination of benefits provision which applies when you are covered by more than one insurance. There are specific laws that mandate the order of payment; therefore, it is necessary to update our records concerning other insurance on an annual basis.

Please fill out this form completely, or it will be sent back.

Failure to return this form within 30-days will result in the denial of your claims.

Spouse's Name (**Print**): _____ DOB: _____

Is your spouse employed? YES ☐ NO ☐ Name of Employer: _____

Is your spouse eligible for coverage through their employer? YES ☐ NO ☐ ***If YES go to Section A**

Do you and/or any member of your family **that is on this plan** have **any other** health, dental or vision coverage? YES ☐ NO ☐

If yes, please complete Sections A, B (if applicable), and D.

If no, please complete Section D.

Do you and/or a member of your family have Medicare coverage? YES ☐ NO ☐

If yes, please complete Sections C and D.

If no, please complete Section D.

SECTION A: OTHER INSURANCE INFORMATION - **please fill out completely to avoid any claim processing delays.**

Did your spouse decline coverage through their employer? YES ☐ NO ☐ ***If YES skip Section A**

Name of Other Insurance Company: _____ _____ Phone: _____ Type of

Insurance: Group Policy ☐ Individual Policy ☐ Medicare Supplement ☐ Other ☐

Type of Coverage: Single ☐ Emp/Child ☐ Emp/Spouse ☐ Family ☐ Spouse Only ☐ Child Only ☐

Type of other Insurance: Medical ☐ Dental ☐ Vision ☐ Prescription ☐

Policy #: _____ _____ Group #: _____ Effective Date: _____ Policy

Holder Name: _____ Policy Holder's Employer: _____

Employment Status: Active ☐ Retired ☐ Unemployed ☐ COBRA ☐ Self Employed ☐

Person Covered Under Other Policy	Relationship

SECTION B:
COMPLETE ONLY IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE DECREE OR OTHER COURT ORDER

Does a court decree or order state who has financial responsibility for providing health coverage for any dependent also covered under this policy? YES ☐ NO ☐

If yes, Name of Responsible Party: _____ Relationship to Child: _____

Child's Name	Custodial Parent Name & Date of Birth	Noncustodial Parent's Name & Date of Birth	Person With Whom Child Lives

Please provide a copy of this page from the court decree or order.

SECTION C: MEDICARE COVERAGE

Subscriber's Name: _____ Effective Date Part A: _____

Effective Date Part B: _____ Effective Date Part D: _____

Reason(s) for Medicare: Age ☐ Disability ☐ End Stage Renal Disease (ESRD) ☐ Disability & ESRD ☐

Spouse's Name: _____ Effective Date Part A: _____

Effective Date Part B: _____ Effective Date Part D: _____

Reason(s) for Medicare: Age ☐ Disability ☐ End Stage Renal Disease (ESRD) ☐ Disability & ESRD ☐

SECTION D: THIS SECTION MUST BE SIGNED BY SUBSCRIBER

To the best of my knowledge this information is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes Medicare, intermediary, or any other insurance carrier or plan to make available to IPMG all information concerning claims filed by me or on my behalf.

Subscriber Signature: _____ Date: _____ Phone #: _____

How can IPMG reach you if we have any further questions? _____

Your assistance in providing a prompt response to this request for information is appreciated. The information may be mailed to: **IPMG Attn: Employee Bene its Services PO Box 3213 Milwaukee, WI 53201, or email it to us at ebscustomerservice@ipmg.com.**

If you have questions regarding this request, please contact our office at 800-423-1841.

Thank you,

IPMG Employee Benefits Services