PO Box 3018
Missoula, MT 59806-3018
Fax: 406-523-3111

CQ

Jul 28, 2021

Dear

Included in this letter, you will find a short form requesting information related to other insurance coverage for yourself and your family. We must request this information to prevent delays in processing your claims. Your cooperation will be greatly appreciated. A response is required prior toany future claims processing, even if the response is that there is no other insurance coverage.

Please take a moment now to complete the form and return it. Alternatively, you may access our website at www.askallegiance.com to complete and submit the form under Online Services, Health Claims Forms, and Coordination of Benefits Questionnaire. Your passcode is CQ. You can also fax the form to us at 1-866-201-0522. 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. Therefore, we strongly encourage you to take the time to respond now. Thank you for your assistance.

If you have any questions regarding this request, please contact our Customer Service Representatives at 1-800-877-1122.

Sincerely,

Allegiance Benefit Plan Management, Inc.

Allegiance®
a Cigna Company

PO Box 3018
Missoula, MT 59806-3018
Fax: 406-523-3111

CQ

Jul 28, 2021

Group #:
Group Name:
Participant Name:
Participant ID #:
Patient Name:

Dear

We have received information that there may be other insurance coverage on the above patient. Please complete the following questionnaire and return it to the address on this letterhead. Pursuant to the claims processing policy adopted by the plan, we must receive this information within 30 days of the date of this letter or claims will be denied. If you have questions please contact our customer service department. Thank you in advance for your prompt attention to this request.

Do you or any other family member have other insurance coverage?
___yes ___no

If yes, please complete the following or go to our website www.askallegiance.com.

Employee
Name of other insurance _____
Address _____
Phone _____ Group Number _____ Policy #_____

Effective date _____ Term date _____
Type of coverage:
____medical ____dental ____vision ____life ____pharmacy ____disability
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 Number _____ Policy #_____
Effective date _____ Term date _____
Type of coverage:
____medical ____dental ____vision ____life ____pharmacy ____disability
Policy Holder _____ Date of Birth _____

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Group #:
Group Name:
Participant ID #:
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 _____
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:
Please complete the following for dependent children in order 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
****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 step-parent cover this child? ____Yes ____No

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Group #:
Group Name:
Participant ID #:
Patient Name:

If separated or divorced, cont'd…

Name of other insurance _____
Address _____
Phone_____ Group Number_____ Policy# _____
Effective Date_____ Term date_____

Type of coverage:
___medical ____dental ____vision ____life ____pharmacy ____disability
Policy Holder _____ Date of Birth _____

Who else is covered under this policy?
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.

_____ Jul 28, 2021
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."

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ملظوحة: إذ كتذ تتحدث اذكر اللغة، إفن خدمات الماسدعة اللغوةي تتوار ف كلا ابلماجن. اتلصـ ربقم 1062-999-855 (مقر

.(855-999-1063 :اهتف اصلم ولاكيم

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063）

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS : 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-999-1062（TTY: 1-855-999-1063）まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).