

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case name	FOR COUNTY USE ONLY	STATE USE ONLY	
Case address	Worker number	Verified by	
	Date	Date	Initials
	Worker telephone number ()	Date	Initials
<input type="checkbox"/> Initial Intake <input type="checkbox"/> Redetermination <input type="checkbox"/> HIPP	<i>Optional</i> District number	Scope	CC number

SECTION I: Beneficiary Information LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY

14-DIGIT MEDI-CAL NUMBER

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co. Code	Aid Code	Case Number	FBU	Pers. No.
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SECTION II: Health Insurance Information

- What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
 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

3. Where do you send your claims?
Name: _____
Address: _____
City, State, ZIP: _____

4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
Name: _____ Social Security number: _____
Address: _____ Telephone number: (____) _____
City, State, ZIP: _____ Absent parent? Yes No

5. What is the policy number? _____

6. What are/were the dates of your policy? Beginning date: _____ Ending date (if applicable): _____
 Medical coverage available through employer, but has not been applied for.

7. Premium amount: \$ _____ Monthly Quarterly Yearly
How are premiums paid? By Insured to insurance carrier By employer By payroll deduction

8. Give name, address, and telephone number of union, employer, group, organization, or school.
Name: _____ Local or group number: _____
Address: _____ Telephone number: (____) _____
City, State, ZIP: _____

9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? Yes No
If yes, please specify the illness: _____

10. 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 Dental care Only specific illness (i.e., cancer)
 Doctor visits Vision care Type of illness: _____

11. Is the policy a Medicare Supplement? Yes No

Remarks: _____

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of applicant	Home telephone (____) _____	Work telephone (____) _____	Date
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RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287

Original—State

Yellow—County File

Pink—(Extra Copy-District Attorney-Beneficiary.)