

HealthChoice
P. O. Box 24870
Oklahoma City, OK 73124-0870



Date:

Name:

Address:

City/State/Zip:

Re: Member ID Number:
Member Name:
Patient Name:

Dear:

We are updating our records. To avoid any future claim payment delays, please provide the following information:

Is your enrolled spouse or dependent(s) covered under any other group health insurance or benefit plan including Medicare? () YES () NO

If YES, please complete the following information:

(1) Insured's name: _____ Date of Birth: _____

(2) Insured's Member Identification number: _____

(3) Employer's name and address: _____

(4) Name, address and telephone number of insured's health insurance company:

(5) Effective date: _____ Termination Date: _____

(6) Coverage type: Single _____ Family _____

(7) Does the plan provide coverage for: Medical () YES () NO
Dental () YES () NO

(8) Name of dependent(s) on the above-mentioned plan (including step-children)

I certify the above information is true and correct to the best of my knowledge.

Member Signature _____ Date _____

(This letter must be signed and dated by the member to be considered complete.)

The member may fax the completed information form to HealthChoice at 1-405-416-1791 or contact our Customer Service Relations Department at 1-405-416-1800 or toll-free at 1-800-782-5218. Our TDD line is 1-405-416-1525 or toll-free at 1-800-941-2160.

Sincerely,
HealthChoice