Other Coverage Questionnaire

Employer: Missouri Consolidated Health Care Plan
Group Number: 76-410425

Welcome to UMR!
We need to collect the following information for you and all covered dependents on your medical plan.

If neither you nor your covered dependent(s) has medical coverage with another company, check the box below.

☐ I and my covered dependent(s) do not have other medical coverage.

If you and/or your covered dependent(s) have other medical coverage, provide the following information:

Name(s) of those with other medical coverage:

_____

Plan holder/Insurance Company Name:

_____

Medical Plan ID Number: _____

Coverage Type: ___ Family ___ Single

Medicare Claim Number (if applicable): _____

Failure to report this information may result in delayed claims payment or termination of dependent coverage.

I hereby certify all information given by me is accurate and true.

_____
Print Name

_____ _____
Signature **Date**

_____
UMR Member ID Number

Please provide this information to UMR by doing one of the following:

- **Call 866-586-0613**
- **Visit umr.com**
- **Mail this form to UMR, PO Box 30787, Salt Lake City, UT 84130-0787**
- **Fax this form to 877-293-4926**

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