Anthem

Other Health Insurance Form

Dear Member:

Anthem Blue Cross and Blue Shield must get data on Other Health Insurance (OHI) from our members. Please fill out this form if you or a family member has OHI. Return it in the enclosed self-addressed, postage-paid envelope or fax to 1-888-393-8993. This data is important, so we can be sure your records are correct.

Member Name	Social Security Number	Member Date of Birth / /

Commercial /HMO/PPO Insurance: Coverage Includes:

Place an 'X' in the box for all that apply. ☐ Medical ☐ Hospital ☐ Major Medical ☐ Pharmacy ☐ Vision ☐ Dental

Insurance Company Name and Address	Insurance Company Phone Number (with area code)
Policy #	Group #
Policyholder's Name	Effective Dates From: / / To: / /
Policyholder's Date of Birth	Policyholder's Social Security Number

Please list all family members covered by this insurance:	
1.	2.
3.	4.

If you have a separate policy for pharmacy, vision or dental coverage, please indicate it here:

Place an 'X' in the box for all that apply. ☐ Pharmacy ☐ Vision ☐ Dental

Insurance Company Name and Address	Insurance Company Phone Number (with area code)
Policy #	Group #
Policyholder's Name	Effective Dates From: / / To: / /
Policyholder's Date of Birth	Policyholder's Social Security Number

Please list all family members covered by this insurance:	
1.	2.
3.	4.

Medicare Coverage:

Medicare (Claim) Number	Medicare Part A Effective Date / /	Medicare Part B Effective Date / /
Member's Name	Social Security Number	

If you have any questions, please call the Customer Care Center at 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711. Thank you.

Other Health Insurance Verification Department