Other Health Insurance Coverage Form

Please provide the information in this form to us using one of the methods below (pick any option that works for you).

✓ **Option 1: Fill out an online DocuSign form:**

1. Go to accesshma.com and then go to **Download Member Forms**.
2. Click on the DocuSign option under **Other Health Insurance Coverage Form**.
3. Fill out and submit the form through DocuSign. You can download a copy of your submission once you're done.

✓ **Option 2: Fill out a downloadable PDF form:**

Note: It's recommended that you *don't* try to complete this PDF form in an Internet browser such as Chrome, Edge, Safari, Firefox, etc., as the form may not work correctly. Instead, please complete the form in a compatible program such as Adobe Reader or Acrobat.

1. Go to accesshma.com and then go to **Download Member Forms**.
2. Click on the PDF option under **Other Health Insurance Coverage Form**.
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat.
4. Email your completed form to: SubmitCOB@accesstpa.com.

✓**Option 3: Email a picture** of the completed form to: SubmitCOB@accesstpa.com (no printing or mailing required)

✓**Option 4: Call** Customer Care at: 800-869-7093.

✓**Option 5: Fax** the completed form to: 866-458-5488

✓**Option 6: Mail** the completed form to:
HMA
Attn: COB Team
PO Box 85016
Bellevue, WA 98015-5016

If you are filling this form out by hand, please write clearly to avoid possible delays in processing. Also, please be sure to list your name, HMA group #, and HMA insurance ID # at the top of each page to ensure your submission can be properly identified. Please return all pages of this form with your submission.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

HMA

Other Health Insurance Coverage Form

HMA Subscriber Name _____ HMA Group # _____ HMA Insurance ID # _____
(This is the person with insurance through HMA) (These items are located on your HMA insurance ID card)

Your Contact Information (in case we need to reach you about your submission)

Phone #: _____ **Email Address**: _____

Reporting Determination (please fill out)

Do you have other health insurance for yourself, your spouse, or your children? (mark **Yes** or **No** below)

○ **Yes** (continue to fill out the next section below)

○ **No**, we only have HMA group health insurance (skip to the last page)

Other Health Insurance Coverage Information

- Within this form the following mean the same thing: A) spouse/domestic partner, B) child/dependent, C) subscriber/policyholder.
- For each additional health insurance policy covering you or your spouse/children, please fill out a separate column below.
- If there are more than two additional health insurance policies, please call Customer Care at (800)-869-7093.

		Other Health Insurance Policy 1	Other Health Insurance Policy 2
1	**Subscriber Full Name** • First name, middle initial, last name, & suffix (e.g. Jr.)		
2	**Subscriber Date of Birth** • In mm/dd/yyyy format		
3	**Subscriber ID #** • Usually listed on ID card • Also known as "Employee ID", "Medicare ID", etc. • Example: ABC123456789		
4	**Subscriber Employer (If Applicable)** • If subscriber has multiple employers, list them in separate columns • If not currently employed, list most recent employer		
5	**Other People on this Same Policy, Including Yourself** Examples: • John Doe - Self • Jane Smith - Spouse • Jim Doe - Son • Judy Smith - Daughter	For each person on this same policy, what's their **name and relationship to this policy's subscriber**?	For each person on this same policy, what's their **name and relationship to this policy's subscriber**?
6	**Policy Type** • If the specific policy type isn't listed here, select the one that best applies	**Pick one:** ○ Individual / Marketplace ○ Group/Employer ○ Medicare ○ Medicaid ○ Student ○ *Tribal/IHS/638 ○ Tricare ○ Veterans Affairs (VA) *Select this option only if this policy *isn't* through HMA.	**Pick one:** ○ Individual / Marketplace ○ Group/Employer ○ Medicare ○ Medicaid ○ Student ○ *Tribal/IHS/638 ○ Tricare ○ Veterans Affairs (VA) *Select this option only if this policy *isn't* through HMA.

Please return all pages of this form with your submission.

HMA

Other Health Insurance Coverage Form

HMA Subscriber Name _____ HMA Group # _____ HMA Insurance ID # _____
(This is the person with insurance through HMA) (These items are located on your HMA insurance ID card)

		Other Health Insurance Policy 1	Other Health Insurance Policy 2
7	**Coverage Type** • Pick at least one	**Pick all that apply:** ☐ Medical ☐ Vision ☐ Dental ☐ Prescription	**Pick all that apply:** ☐ Medical ☐ Vision ☐ Dental ☐ Prescription
8	**Policy Start Date** • Even if policy is cancelled, still enter this date	**Policy became effective on (mm/dd/yyyy):**	**Policy became effective on (mm/dd/yyyy):**
9	**Policy End Date** • Skip if policy is still active	**Policy was cancelled as of (mm/dd/yyyy):**	**Policy was cancelled as of (mm/dd/yyyy):**
10	**Insurance Carrier Name** • Usually listed on ID card		
11	**Insurance Carrier Phone #** • Usually listed on ID card • Include area code		
12	**Subscriber COBRA Status** • Skip if not on COBRA • If subscriber has COBRA coverage, list the effective date *and* the employer it's through	**On COBRA as of (mm/dd/yyyy):** **COBRA coverage is through** (list employer name):	**On COBRA as of (mm/dd/yyyy):** **COBRA coverage is through** (list employer name):
13	**Subscriber Retiree Status** • Skip if not retired • List the retirement date • If subscriber has retiree health insurance coverage, list the employer it's through	**Retired as of (mm/dd/yyyy):** **Retiree coverage is through** (list employer name):	**Retired as of (mm/dd/yyyy):** **Retiree coverage is through** (list employer name):

If not on Medicare, skip to the next page; otherwise, continue to the next question.

		Other Health Insurance Policy 1	Other Health Insurance Policy 2
14	**Subscriber Medicare Entitlement Reason(s)** • Skip if not on Medicare	**On Medicare because of (pick all that apply):** ☐ Age ☐ End Stage Renal Disease (ESRD) ☐ Disability	**On Medicare because of (pick all that apply):** ☐ Age ☐ End Stage Renal Disease (ESRD) ☐ Disability
15	**Subscriber Medicare Effective Date(s)** • Skip if not on Medicare • In mm/dd/yyyy format	**On Medicare as of (provide all that apply):** **Part A:** **Part B:** **Part D:**	**On Medicare as of (provide all that apply):** **Part A:** **Part B:** **Part D:**

Please return all pages of this form with your submission.

HMA

Other Health Insurance Coverage Form

HMA Subscriber Name _____ HMA Group # _____ HMA Insurance ID # _____
(This is the person with insurance through HMA) (These items are located on your HMA insurance ID card)

Custody/Court Order Assessment

Question 1
Is the subscriber divorced or separated from any of the children's other parent(s)?
- ○ **Yes**: Continue to question 2→
- ○ **No**: Skip to the **Employee Attestation** section

It doesn't matter if the children are biologically-related to the subscriber or not.
It also doesn't matter if the subscriber and/or the other parent(s) have since re-married other people.

Question 2
Is there documentation (like a divorce decree) indicating who's financially responsible for the children's health insurance?
- ○ **Yes**: Please fill out the **Custody/Court Order Information** section below **AND include copy of court/divorce decree**
- ○ **No**: Please fill out the **Custody/Court Order Information** section below

Examples of applicable documentation: Court order, custody agreement, divorce decree, parenting plan, etc.

Custody/Court Order Information

		Child 1 Information	Child 2 Information	Child 3 Information
1	**Full Name of Child** List each child's *current* full name			
2	**Person with Custody of the Child(ren) over 50% of the Time:** A. Full Name B. Date of Birth (mm/dd/yyyy) C. Their Relationship to Each Child • Examples: Biological mother/father, adoptive grandmother/grandfather, mother/father-in-law, etc.	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child:	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child:	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child:
3	**Person with Financial Responsibility for Health Coverage of Each Child per Court/Divorce decree** (skip if no such decree is in place): A. Full Name B. Date of Birth (mm/dd/yyyy) C. Their Relationship to Each Child D. End Date of Financial Responsibility (If Applicable)[1]	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child: D. Responsibility End Date:	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child: D. Responsibility End Date:	A. Full Name: B. DOB (mm/dd/yyyy): C. Relationship to Child: D. Responsibility End Date:

! YOU MUST INCLUDE CURRENT DOCUMENTATION FOR EACH CHILD LISTED ABOVE
Examples: Court order, custody agreement, divorce decree, parenting plan, etc.

Employee Attestation

By providing your name, group #, and insurance ID # above and submitting this form you attest that the information listed herein is correct to the best of your knowledge and that you are either the employee referenced herein or their authorized representative.

[1] End Date of Financial Responsibility: If the court order, custody arrangement, divorce decree, etc., state that this person's responsibility to provide health coverage for this child ends once a certain date is reached (such as when the child turns 18 years old), what's that end date?

Please return all pages of this form with your submission.