Baylor Scott & White Health Plan

BAYLOR SCOTT & WHITE HEALTH PLAN
1206 WEST CAMPUS DR
TEMPLE TX 76502

Forwarding Service Requested

Other Insurance Survey

03/20/2025

J1OA 1

ACTION NEEDED

Dear MEMBER NAME:

Please take a moment to let us know if you and/or your dependents have other health insurance. We ask that you update, verify, or provide other coverage information at least once a year. List and provide information for all members covered under your policy.
If you and/or your dependents do not have other healthcare coverage, please check the "No other coverage" box below.

To submit this questionnaire, please do one of the following:
- Update your information on our online Member Self-Service Portal at MyBSWHealth.com.
- Call the customer service number on the back of your ID card
- Mail this completed form to:
  Baylor Scott and White Health Plan
  Attn: COB Department
  1206 West Campus Dr.
  Temple, TX 76502

If you have any questions or need additional information, contact us at the customer service phone number on the back of your ID card.

Scott and White Health Plan Member Information	Other Healthcare Coverage
Member Name: _____ Member ID#: _____	❑ Medicare ❑ Medicaid ❑ Other ❑ No other coverage
Member Name: _____ Member ID#: _____	❑ Medicare ❑ Medicaid ❑ Other ❑ No other coverage
Member Name: _____ Member ID#: _____	❑ Medicare ❑ Medicaid ❑ Other ❑ No other coverage
Member Name: _____ Member ID#: _____	❑ Medicare ❑ Medicaid ❑ Other ❑ No other coverage
Member Name: _____ Member ID#: _____	❑ Medicare ❑ Medicaid ❑ Other ❑ No other coverage

Policy No. 1: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (list covered dependents in box below)

Other Insurance Information:	**Other Coverage Policyholder Information:**
Plan Name:_____ Phone Number:_____	Name: _____
Policy Number: _____Group Number: _____	Relationship: _____
Effective Date: _____ Termination Date: _____	Social Security Number: _____
Is it a retiree policy? ❑ Yes ❑ No	Date of Birth: _____
Is this court-ordered coverage? ❑ Yes ❑ No	List Dependents covered by this policy:
Coverage type (check all that apply):	_____
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental	_____

Policy No. 2: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (list covered dependents in box below)

Other Insurance Information:	**Other Coverage Policyholder Information:**
Plan Name:_____ Phone Number:_____	Name: _____
Policy Number: _____Group Number: _____	Relationship: _____
Effective Date: _____ Termination Date: _____	Social Security Number: _____
Is it a retiree policy? ❑ Yes ❑ No	Date of Birth: _____
Is this court-ordered coverage? ❑ Yes ❑ No	List Dependents covered by this policy:
Coverage type (check all that apply):	_____
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental	_____

Medicare Coverage: Please complete this section if you or your spouse are covered by Medicare.

Policy No. 1: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (Name:_____)

Medicare Policy Number: _____	Current work status: _____
Eligibility due to:	If employed—Company Name:
❑ Age 65 or older ❑ Disability ❑ End Stage Renal Disease	_____
Do you have Part A? ❑ Yes ❑ No Effective Date: _____	If retired—Retirement Date:_____
Do you have Part B? ❑ Yes ❑ No Effective Date: _____	Do you work with another company? ❑ Yes ❑ No
Do you have Part D? ❑ Yes ❑ No Effective Date: _____	If yes—Employer Name: _____

Policy No. 2: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (Name:_____)

Medicare Policy Number: _____	Current work status: _____
Eligibility due to:	If employed—Company Name:
❑ Age 65 or older ❑ Disability ❑ End Stage Renal Disease	_____
Do you have Part A? ❑ Yes ❑ No Effective Date: _____	If retired—Retirement Date:_____
Do you have Part B? ❑ Yes ❑ No Effective Date: _____	Do you work with another company? ❑ Yes ❑ No
Do you have Part D? ❑ Yes ❑ No Effective Date: _____	If yes—Employer Name: _____

Medicaid Coverage: Please complete this section if you, your spouse and/or dependent(s) are covered by Medicaid.

Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-572-7238 (TTY: 711). Baylor Scott & White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-572-7238 (TTY: 711). Baylor Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-572-7238 (TTY: 711). Baylor Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.