new mexico health connections

Other Insurance (Coordination of Benefits) Questionnaire

Subscriber Name	
Patient Name	
Employer Name	
Member ID Number	

Our records indicate the patient may have other insurance that could affect the benefits payable under your New Mexico Health Connections (NMHC) Plan. Providing the information requested will help avoid any delays in processing your family's health claims. **If coverage has terminated, please provide your letter of creditable coverage provided by the other insurance company.**

Please complete the information below, sign, and return to the address at the bottom of this form. Thank you.

Is the patient covered by Medicare?	☐ NO ☐ YES (If YES, please submit a copy of the patient's Medicare card.)
Is the patient covered by any other health insurance in addition to this NMHC Plan?	☐ NO ☐ YES (If YES, please complete the information below.)
Name of Insured Person	
Relationship to the Patient	
Employer Name and Address	
Employer Telephone Number	( )
Insurance Co. Name and Address	
ID Number and Group Number	
Insurance Co. Telephone Number	( )

TYPES OF COVERAGE	SINGLE/FAMILY	EFFECTIVE DATE/CANCELLATION DATE
Medical: ___ Yes ___ No	_____/______	___________________/_____________________
Dental: ___ Yes ___ No	_____/______	___________________/_____________________
Vision: ___ Yes ___ No	_____/______	___________________/_____________________
Rx Card: ___ Yes ___ No	_____/______	___________________/_____________________

Insured's date of birth: _____________ Active Employee Plan: ____ Retired Employee Plan: ____

Birthday Rule: ___ Yes ___ No Coordination of Benefits Provision: ___ Yes ___ No

Signature: ____ Date: _____________________________

Please send completed form to:

- Via mail: New Mexico Health Connections, P.O. Box 211468, Eagan, MN 55121
- Via email: info@mynmhc.org
- Via fax: 1-312-548-9943

If you have any questions, please call NMHC Customer Service at 1-855-769-6642.