Denver Metro
P.O. Box 3559
Englewood, CO 80155-3559
10771 E. Easter Ave.
Suite 250
Centennial, CO 80112
Telephone (303) 770-5710
Fax (303) 770-2743

CNIC Health Solutions®
A Rocky Mountain Health Plans TPA
www.cnichs.com

Colorado Springs
740 Wooten Road, Suite 104
Colorado Springs, CO 80915
Claims Only: P.O. Box 76149
Colorado Springs, CO 80970
Telephone (719) 622-3300
Fax (719) 591-8817

Group Number: _____
Employee: _____
Patient: _____
Claim Number: _____

Our records indicate that we need updated information on possible other insurance coverage for your family. This information is only requested annually, on the initial claim, or due to a change in status.

In order to properly administer your benefits, we need to know if anyone in the family has any other insurance coverage. Other coverage would include group coverage through an employer other than the one referenced above, Medicare, Medicaid, any other type of coverage, and coverage mandated by a decree or through a non-custodial parent.

Does anyone in the family have other medical or dental coverage?

If NO, please indicate here, sign and return this form as indicated below.
No Other Coverage _____

If YES, please complete the following:

MEDICAL COVERAGE

Name of the carrier _____
Phone number of the carrier _____
Policyholder's ID number _____
Policyholder's date of birth _____
Effective date of coverage _____
Is this single or family coverage? _____
If single coverage, what family member is covered on the plan? _____
If family coverage, what family member(s) are covered on the plan? _____
_____
Is this a group policy _____ or an individual/supplemental policy? _____

DENTAL COVERAGE

Name of the carrier _____
Phone number of the carrier _____
Policyholder's ID number _____
Policyholder's date of birth _____
Effective date of coverage _____
Is this single or family coverage? _____
If single coverage, what family member is covered on the plan? _____
If family coverage, what family member(s) are covered on the plan? _____
Is this a group policy _____ or an individual/supplemental policy? _____

Please sign and date where indicated below and provide us with your phone number so that we may contact you in the event we have more questions.

Signature of Enrollee _____
Date signed _____
Phone number _____

Please submit requested information as soon as possible so that we can complete your claim.

Thank you for your cooperation.

CNIC Health Solutions