DHS Oregon Department of Human Services

SHARED SERVICES
Office of Payment Accuracy and Recovery

Oregon Health Authority

Notification of Other Health Insurance

Office use only		
Branch:	Worker ID:	Case number:

☐ Rush processing needed
Reason for rush _____

Note: *Rush processing should only be requested when there is an immediate/urgent need for health services.*

Good cause coding:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Use this form to report employer sponsored or other private health insurance policies for an individual that may also be receiving or applying for Medicaid.

Instructions:

Applicants — Complete sections 1— 5 and return this form to your caseworker with a copy of the front and back of your insurance cards.

Workers, managed care plans and providers — Complete sections 1 — 4 and return this form to the Health Insurance Group by email or FAX: 503-373-0358.

Section 1: Contact information

Name of person completing this form:
Are you a: ☐ Applicant ☐ Caseworker ☐ Provider ☐ Managed care plan ☐ Other
Phone number:
Email address:

Section 2: Status of insurance - check all that apply

☐ Have active insurance
☐ Insurance has changed
☐ Insurance is COBRA
☐ Can get insurance from employer
☐ Insurance ended on ____/____/____
☐ Insurance is from an employer
☐ Insurance is paid for privately

If you pay for all or part of your insurance, we may be able to reimburse you. For more information, see section number 5 on the next page.

Section 3: Policy 1 information

Insurance company:		Policy ID number:
Policy holder's* name (first, middle initial, last)	Social Security number:	Date of birth (month, day, year)
Type of policy (check all that apply): ☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision ☐ Other: _____		

* The policy holder is the **owner** of the insurance policy.