

CLIENT HEALTH INSURANCE (TPL) INFORMATION

THE EXISTENCE OF PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDICAID ELIGIBILITY.

For information about how Medicaid coordinates with primary health insurance, see the brochure "A Guide For Medicaid Clients Who Have Other Health Insurance." State Forms Commodity #615-82-94-1886.

|   |  |                                 |     |     |      |
|---|--|---------------------------------|-----|-----|------|
| NEW INSURANCE: <input type="checkbox"/> | Changing from an old health plan to a new health plan requires two (2) MS-10 forms (2) | ENTER DATE INSURANCE ENDED: (3) | Mo. | Day | Year |
|---|--|---------------------------------|-----|-----|------|

|  |                               |
|--|-------------------------------|
| COUNTY WORKER'S NAME (Please Print Last, First): (4) | PHONE NUMBER: (5)<br>( ) ext. |
|--|-------------------------------|

This form must be completed for all clients who are eligible for Medical Assistance and have private health insurance coverage. (ALL SHADED AREAS MUST BE COMPLETED.) Mailing address to submit completed form is on the reverse side.

|                             |                 |
|-----------------------------|-----------------|
| CASE NAME (Last, first) (6) | CBMS NUMBER (7) |
|-----------------------------|-----------------|

| COVERED INDIVIDUALS (8)            |              |                               |               | CLIENT'S RELATIONSHIP (6)<br>TO POLICYHOLDER<br>(policyholder, spouse, child, other) |
|------------------------------------|--------------|-------------------------------|---------------|--|
| CLIENT'S (8)<br>NAME (Last, First) | STATE ID (b) | SOCIAL (c)<br>SECURITY NUMBER | BIRTHDATE (d) |  |
| -----                              | -----        | -----                         | ---/---/---   |  |
| -----                              | -----        | -----                         | ---/---/---   |  |
| -----                              | -----        | -----                         | ---/---/---   |  |
| -----                              | -----        | -----                         | ---/---/---   |  |

The below information can be obtained from the front and back of your health insurance card. Attach a front & back copy to this form. NAME OF HEALTH INSURANCE COMPANY: (9)

|  |
|--|
| PHONE NO. (To Verify Coverage and/or Benefits) (10)<br>( ) |
|--|

|   |            |             |           |
|---|------------|-------------|-----------|
| ADDRESS FOR SUBMISSION OF HEALTH CLAIMS: (11) | CITY: (12) | STATE: (13) | ZIP: (14) |
|---|------------|-------------|-----------|

|                               |   |                                |
|-------------------------------|---|--------------------------------|
| POLICY/MEMBER/ID NUMBER: (15) | POLICYHOLDER'S SOCIAL SECURITY NUMBER: (16) | GROUP NUMBER or EMPLOYER: (17) |
|-------------------------------|---|--------------------------------|

|   |          |  |                       |
|---|----------|--|-----------------------|
| POLICYHOLDER/MEMBER/ (18)<br>EMPLOYEE NAME (Last, First): | DOB (18) | POLICYHOLDER'S ADDRESS (must include zip code): (19) | PHONE NO. (20)<br>( ) |
|---|----------|--|-----------------------|

I authorize any person, medical provider, insurance company, or other organization to provide any information about me or my dependent's health insurance, medical treatment and employment to the Department of Health Care Policy & Financing upon request. (Copies of this form are legal.)

|                    |                                       |            |
|--------------------|---------------------------------------|------------|
| (21)<br>SIGNATURE: | DAYTIME TELEPHONE NUMBER: (22)<br>( ) | DATE: (23) |
|--------------------|---------------------------------------|------------|

NOTE ON HEALTH INSURANCE BUY-IN PROGRAM (HIBI)

If you want help paying your private health insurance premiums, complete the Health Insurance Buy-In (HIBI) Request Form, Commodity #615-82-92-2041 BOTH the MS-10 Form AND the HIBI Request Form are required in order to process a HIBI request. For more information about the HIBI program, ask your county technician for the HIBI brochure, Commodity #615-82-92-2037.

STATE USE ONLY

|                |                              |              |            |   |
|----------------|------------------------------|--------------|------------|---|
| DATE VERIFIED: | CONTACT:                     | COV'G BEGIN: | COV'G END: | POLICY TYPE:  |
|                |                              |              |            | HMO PPO POS M'CARE SUPPL A B<br>M'CARE HMO MILITARY COBRA |
| DEDUCTIBLE:    | PHARMACY PROCESSOR & CAP AMT |              |            | DENTAL PROCESSOR  |

COVERED SERVICES

|                |              |              |                 |
|----------------|--------------|--------------|-----------------|
| Lab/Diag       | Outpatient   | Supplies/DME | Skilled Nursing |
| Exp/Presch     | Practitioner | Home Health  | Lab & Xray      |
| Transportation | Dental       | Drugs        | Pre-Paid        |
| CPSE           |              |              |                 |

## INSTRUCTIONS FOR COMPLETING THIS FORM

We will need to call your insurance company and verify that the information on this form is correct. To do that, **ALL SHADED AREAS MUST BE COMPLETED**. Or, you can attach a copy of the FRONT AND BACK of your insurance card (Make sure it is a clear copy). **PLEASE PRINT** and use **BLACK INK** only.

- 1) Check this box if you are reporting a new health insurance plan.
- 2) When changing from an old health insurance plan to a new plan, **two (2) MS-10 forms** must be completed: the first to report the **date the old plan ended**, and the second to report the **new health insurance plan information**.
- 3) Enter the date (month/day/year) your health insurance coverage ended.
- 4) Print the name (last, first) of your county technician.
- 5) Print your county technician's phone number, with area code and extension.
- 6) Print the case name (last, first) of your case.
- 7) Print the CBMS number of your case.
- 8) List all the persons who are **BOTH** on Medicaid **AND** covered by your health insurance plan. Print clearly:
  - a) Client's name (last, first)
  - b) Client's State ID (e.g., Y123456)
  - c) Client's Social Security Number (e.g., 123-45-6789)
  - d) Client's Date of Birth (month/day/year)
  - e) Client's Relationship to the Policyholder (e.g., self, policyholder's spouse, child, other)
- 9) Print the Name of your Health Insurance Company (e.g., Aetna, Kaiser, Principal, etc.)
- 10) Print the Phone Number of the Insurance Company to call to verify coverage and/or benefits (**not** the pre-authorization or pre-certification phone number).
- 11) Print the address (PO Box or Street Address) where claims are sent for processing.
- 12) Print the full name of the City where claims are sent for processing. Please do not abbreviate.
- 13) Print the State (2-letter abbreviation) where claims are sent for processing.
- 14) Print the Zip Code where claims are sent for processing.
- 15) Print the Policy/Member ID Number of the primary policyholder (usually, but not always, the policyholder's social security number) (**NOT** the plan number or group number).
- 16) Print the Policyholder's Social Security Number. Sometimes the policy number is not available. **ALWAYS** print the Policyholder's Social Security Number.
- 17) Print the Group Number or Employer Name, if any. **DO NOT** put this number in the Policy Number field.
- 18) Print the Name of the Primary Policyholder/Member/Employee (last, first) and **Date Of Birth** (month/day/year).
- 19) Print the Policyholder's Address. **Must** include Street Address or PO Box, City, State, and **zip code**.
- 20) Print the Policyholder's Phone Number, if it is available. Please include the area code.
- 21) Sign the MS-10 form. (**THIS IS A MUST!**) If anyone other than the client or Policy Holder signs the form, a copy of the Power of Attorney or Designation of Personal Representative form plus a copy of the client's Medicaid card and the POA's driver's license **MUST** be attached.
- 22) Print the Daytime Telephone Number of the head of this case (is the main contact person for this case).
- 23) Print the Date this form was signed (month/day/year).

----- Call for a -----

stamp

### MAIL TO:

HEALTH CARE POLICY & FINANCING  
BENEFITS COORDINATION TPR SECTION  
1570 GRANT STREET FIFTH FLOOR  
DENVER CO 80203-1818