



01 \_\_\_\_\_ 02 \_\_\_\_\_ 03 \_\_\_\_\_ 04 \_\_\_\_\_

Dear Subscriber:

Date:

We have recently received a claim/enrollment form/change card for the patient/dependent named below. We must have additional information before this can be processed. Please answer all questions, sign and return this form to us by . Failure to return the completed form by the requested date will cause your claim to be rejected, or will delay processing of your enrollment form or change card. Completion of this form may be required periodically.

SECOND REQUEST (IF BOX IS CHECKED)

Table with 2 columns: PATIENT/DEPENDENT NAME, DAY TIME PHONE NO., CONTRACT NUMBER, DATE OF SERVICE, GROUP NUMBER.

FOLD

1. . . .  YES  NO Is dependent less than 25 years old? DATE OF BIRTH DATE DEPENDENCY BEGAN SEX  M  F
2. . . .  YES  NO Is dependent married?  Single  Married  Widowed  Divorced  Separated
3. . . .  YES  NO Is dependent covered under any other insurance contract? If yes, give name of company and policy number. NAME POLICY NO.
4. . . .  YES  NO Does dependent rely upon you for financial support?
5. . . .  YES  NO Does dependent reside with you? IS DEPENDENT YOUR  NATURAL CHILD  ADOPTED CHILD  CHILD FROM A PREVIOUS MARRIAGE  OTHER (explain on other side)
6. . . .  YES  NO Is dependent a full time student? NAME AND ADDRESS OF SCHOOL NOW ATTENDING
STUDENT ID NUMBER CURRENT TERM FROM TO EXPECTED DATE OF GRADUATION ORIGINAL ENROLLMENT DATE
7. . . .  YES  NO Has dependent been a full-time student since reaching age 21?
8. . . .  YES  NO Is dependent mentally or physically incapacitated? If yes, please attach medical documentation from your doctor with an explanation of:
A. Diagnosis of condition(s) causing incapacitation
B. Date patient/dependent first became incapacitated
C. Anticipated length of incapacitation
 Additional information needed

CERTIFICATION BY SUBSCRIBER - READ CAREFULLY - THIS SECTION MUST BE SIGNED BY SUBSCRIBER

I, \_\_\_\_\_, certify that the foregoing information is correct to the best of my knowledge, and agree to the following: (Please print name of subscriber)

- 1 . . . I will inform Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. of any changes affecting the above dependent's status.
2 . . . I agree to refund to Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. any monies paid by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. on the above dependent should that dependent at any time not qualify under the above guidelines and during that period of qualification Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. paid monies for the above dependent based on the certification, and
3 . . . I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify, directly or indirectly, or through its authorized agents, any of the foregoing information.

Date \_\_\_\_\_ Subscriber's Signature \_\_\_\_\_

OFFICE USE ONLY table with columns: UW Int., Approved, Not Aprvd.