

# Other Health Insurance (OHI) form

For Total Choice, PLUS, and Community Choice members



If you or a family member have health coverage from a health plan other than Wellpoint, we've made using coverage from both plans more convenient. Your Wellpoint plan has a coordination of benefits (COB) provision. That means Wellpoint works with the other plan to determine which of your plans can provide coverage.

You may need to fill out this and send it to Wellpoint to let us know if you are using more than one plan.

## You don't need to fill out this form if:

- Your only health coverage is from Wellpoint, **or**
- Your other health coverage is from Medicare, AARP, MassHealth, or TRICARE, **or**
- Your other coverage is for dental, vision, or life insurance, **or**
- You've filled out this form before and your coverage hasn't changed.

## You do need to fill out this form if:

- You have coverage from another health plan (that isn't Wellpoint, Medicare, AARP, MassHealth, or TRICARE), **and**
- You've either never completed an OHI form before or the information you provided needs to be updated.

## How to submit the form

You can fill in the fields below, fold the form (with the Wellpoint address on the outside), and seal it shut. The form is postage paid; just drop the completed form in the mail. You can also fax the completed form to **978-474-5162** or email it to [contact.ma@wellpoint.com](mailto:contact.ma@wellpoint.com).

## We are here to help

If you have questions, call Wellpoint Member Services at **833-663-4176** (TTY: 711) or email us at [contact.ma@wellpoint.com](mailto:contact.ma@wellpoint.com).

| Part A: About the Wellpoint enrollee   |            |           |  |                |          |
|--|------------|-----------|--|----------------|----------|
| Last name  | First name | M.I.      | Street address   |                |          |
| Wellpoint enrollee ID number   |            |           | City   | State          | ZIP code |
| Part B: About the other health coverage  |            |           |  |                |          |
| Other health plan name   |            |           | Plan street address  |                |          |
| Plan telephone number  |            |           | City   | State          | ZIP code |
| Name of policyholder   |            | ID number | Group number   | Effective date |          |
| Policyholder's relationship to Wellpoint enrollee<br>Self Spouse Child Other (explain) |            |           | Are all family members covered under this plan? Yes No<br>If no, who is covered? |                |          |

I hereby acknowledge that the information I have provided on this form is correct and complete to the best of my knowledge.

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_



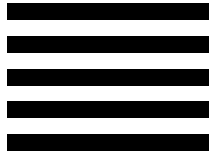


NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES

**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL PERMIT NO. 49 ANDOVER, MA

POSTAGE WILL BE PAID BY ADDRESSEE

WELLPOINT  
PO BOX 4095  
WOBURN MA 01888



**If you have other health insurance  
(besides Wellpoint)**

Please read the instructions to see  
if you need to complete this form.