UniCare

UNICARE STATE INDEMNITY PLAN

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 UniCare, we've made using coverage from both plans more convenient. Your UniCare plan has a Coordination of Benefits (COB) provision. That means UniCare 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 UniCare 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 UniCare, **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 will need to fill out this form if:

- You have coverage from another health plan (that isn't UniCare, 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

You can fill in the fields below, fold the form (with the UniCare 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.us@anthem.com.

We are here to help

If you have questions, call UniCare Member Services at 833-663-4176 (TTY: 711) or email us at contact.us@anthem.com.

PART A: About the UniCare enrollee					
Last name	First name	M.I.	Street address		
UniCare 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 UniCare enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (explain)			Are all family members covered under this plan? ☐ Yes ☐ No 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

UNICARE
PO BOX 9016
ANDOVER MA 01810-9919

UniCare℠

If you have other health insurance (besides UniCare)

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