



## Other Parent Insurance Information

### PARTICIPANT

Participant Name:	Social Security Number/MPI-ID#:
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### DEPENDENT

Name:	SSN:
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Address:

### OTHER BIOLOGICAL PARENT

Name:	Date of Birth:
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Address:

Marital Status of biological parents:  
 Married     Never Married     Divorced **Please submit a copy of divorce decree with custodial and/or health insurance orders**

Does the other biological parent have insurance that covers the above dependent? <input type="checkbox"/> Yes ( <b>Provide insurance information below</b> ) <input type="checkbox"/> No	Is a premium required for Group Insurance for children? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Insurance Name:		<input type="checkbox"/> Medical/Hospital	<input type="checkbox"/> HMO	<input type="checkbox"/> RX
Policy Number:	Group Number:	Effective Date	Cancellation Date	

**If the other biological parent is married, please provide the following information:**

### STEP PARENT

Name:	Date of Birth:
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Address:

Does the step parent have insurance that covers the above dependent?  
 Yes (**Provide insurance information below**)  No

Insurance Name:		<input type="checkbox"/> Medical/Hospital	<input type="checkbox"/> HMO	<input type="checkbox"/> RX
Policy Number:	Group Number:	Effective Date	Cancellation Date	

### LEGAL GUARDIAN OR OTHER

Name:	Date of Birth:
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Address:

Does this person have insurance that covers the above dependent?  
 Yes (**Provide insurance information below**)  No

Insurance Name:		<input type="checkbox"/> Medical/Hospital	<input type="checkbox"/> HMO	<input type="checkbox"/> RX
Policy Number:	Group Number:	Effective Date	Cancellation Date	

**I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT**

Participant Signature	Date
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## Coordination of Benefits Questionnaire for Dependent Children

Like most group plans, your benefits through MPI are subject to a provision against duplication with other employer group health plans. This provision does not apply to individual policies.

The completion of this questionnaire will allow the MPI to make the proper order of payments for your dependent(s). A process known as order of benefit determination is used to coordinate the benefits of both plans where duplicate coverage exists. In order to properly coordinate with other group health plans, MPI must first determine this order of benefits.

You are required to complete this questionnaire if your dependent(s) falls under any of these categories:

- 1) Your dependent is over age and is enrolled in his/her own employer group health plan
- 2) You have non-biological children (stepchildren, legal guardian, etc.).
- 3) You are not married to the parent of your biological children.
- 4) You are not married to the parent of your biological children and their previous insurance has changed/ cancelled. (Indicate on the form previous policy cancellation date and current policy information)
- 5) Your biological children are covered under another policy as ordered by the Court.
- 6) You are divorced or are divorcing the parent of your biological children. (You must submit a copy of your divorce decree (include all pages) and/or a copy of the Court order that contains insurance and/or custodial orders).

Failure to submit this questionnaire or report a change in coverage will result in the denial of claims.

### Overage dependents with employer provided group coverage

Your children, ages 19 to 26, who are enrolled in their employer provided group coverage may still be covered under MPI. However, the coverage through the dependent's employer would pay primary for the claims the dependent incurs. Furthermore, if the dependent loses or terminates his/her employer provided group coverage, MPI requires that a Certificate of Prior Creditable Coverage be presented to establish the effective date of primary coverage under MPI.

### Submission and Payment of Claims

Claims should be submitted within 90 days from the date services were rendered for an illness or injury, but no later than 15 months from the date of service or, in coordination of benefits situations, 15 months from the date the primary payer paid. Failure to timely file may result in the denial of your claim. **A request for review of any adverse decision on a claim must be made within 180 days of the date on the Explanation of Benefits (EOB) form.**

Should you or your dependent's insurance information change, please notify MPI's Participant Services Center at [service@mpiphp.org](mailto:service@mpiphp.org) or call toll-free (855) ASK-4MPI (855-275-4674) from 8 a.m. to 5 p.m. PST, Monday through Friday. *Failure to provide this information may result in the delay and/or denial of payment for your dependent's claims.*