Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin AIDS Drug Assistance Program, Wisconsin Chronic Disease Program
To: All Providers, HMOs and Other Managed Care Programs

Changes to Reporting Other Coverage Discrepancies for Commercial Insurance and Medicare Coverage

ForwardHealth has revised the Other Coverage Discrepancy Report, F-01159 (09/12), and renamed it as the Commercial Other Coverage Discrepancy Report, F-01159 (04/2017). Additionally, a new form, the Medicare Other Coverage Discrepancy Report, F-02074 (04/2017), has been created for providers to use to notify ForwardHealth of discrepancies with a member's Medicare coverage information.

To more accurately identify members and other health insurance information on file with ForwardHealth, ForwardHealth is implementing changes to the policy for reporting other coverage. ForwardHealth has revised the Other Coverage Discrepancy Report, F-01159 (09/12), and renamed it the Commercial Other Coverage Discrepancy Report, F-01159 (04/2017). Additionally, a new form, the Medicare Other Coverage Discrepancy Report, F-02074 (04/2017), has been created for providers to use to notify ForwardHealth of discrepancies with a member's Medicare coverage information. ForwardHealth has created completion instructions for both forms for providers to use as a reference when completing the forms.

Changes to the Other Coverage Discrepancy Report

ForwardHealth has revised and renamed the Other Coverage Discrepancy Report (dated 09/12). The form has been renamed the Commercial Other Coverage Discrepancy

Report (dated 04/2017). Fields for Medicare Parts A and B coverage information from the 09/12 version of the form have been removed in the 04/2017 form. ForwardHealth will continue to accept 09/12 versions of this form until November 8, 2017. On and after November 8, 2017, only the 04/2017 version of the form will be accepted and the previous version of the form received by ForwardHealth will be returned to the provider unprocessed.

Revisions to the Commercial Other Coverage Discrepancy Report include:

- Providers may now select "Delete" as the reason for the report, in addition to "Add" or "Change."
- The options for coverage type are "Commercial," "Medicare Supplemental," and "Long Term Care."
- The following fields have been added to Section II:
  - ✓ Carrier Number
  - ✓ Policyholder – Date of Birth
  - ✓ Policyholder – Gender
  - ✓ Policyholder – Relationship to Member
  - ✓ Group Number
  - ✓ Commercial or Medicare Supplemental Coverage Types
  - ✓ Long Term Care Coverage Only
  - ✓ Open-Ended Coverage?

Department of Health Services

Refer to Attachments 1 and 2 of this *Update* for a copy of the revised form and completion instructions.

Other Coverage Discrepancy Report Online Submission

ForwardHealth has updated the Commercial Other Coverage Discrepancy Report form on the Portal. Providers may now fill out information fields with the discrepancy information, and the data will be entered automatically onto the form, which the provider may then submit. Providers can access this form from their secure Portal account home page under the Quick Links section.

Medicare Other Coverage Discrepancy Report

As a part of the revision to the Other Coverage Discrepancy Report, ForwardHealth has created the Medicare Other Coverage Discrepancy Report. This form is to be used by providers to notify ForwardHealth of coverage discrepancies, obtained through Wisconsin's Enrollment Verification System or information received from another source, with Medicare Parts A, B, and/or D, Medicare Advantage, and/or Medicare Cost coverage information. ForwardHealth will verify the provided information and update the other coverage information on file for the member, as applicable. Refer to Attachments 3 and 4 for a copy of the new form and completion instructions.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

ATTACHMENT 1
Commercial Other Coverage Discrepancy Report Completion Instructions

(A copy of the "Commercial Other Coverage Discrepancy Report Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT
COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Personally identifiable information about applicants and members is confidential and is only used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the Commercial Other Coverage Discrepancy Report form, F-01159, may result in denial of payment for the services.

Provision of a Social Security number (SSN) is mandatory under the provisions of the Affordable Care Act. The SSN will be used for coordination of benefits purposes. Use or disclosure of any information concerning a policyholder (including a policyholder's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the policyholder (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

> ForwardHealth
> Coordination of Benefits
> PO Box 6220
> Madison WI 53716-6220

Allow five to seven business days for processing.

Type or print clearly. Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System (EVS) and information received from another source. Always complete Sections I and V. Complete Sections II, III, and/or IV as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly.**

INSTRUCTIONS

SECTION I – PROVIDER AND MEMBER INFORMATION

Element 1 – Name – Provider
Required. Enter the provider's name.

Element 2 – Provider ID/National Provider Identifier
Required. Enter the provider's National Provider Identifier (NPI) or Medicaid provider ID.

Element 3 – Name – Member
Required. Enter the member's complete name.

Element 4 – Date of Birth – Member
Required. Enter the member's date of birth in MM/DD/CCYY format.

Element 5 – Member ID
Required. Enter the member's Medicaid member ID.

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE

Element 6
Required. Indicate whether the policy type is being added, changed, or deleted from the member's insurance.

Element 7 – Policy Type
Required. Indicate the policy being added, changed, or deleted is commercial, Medicare Supplemental, or Long-Term Care (LTC) Only.

Element 8 – Carrier Number
Required. Enter the number associated with the insurance company, found on the EVS. Providers can access the EVS to receive the most current enrollment information through the following methods:
- ForwardHealth Portal at *www.forwardhealth.wi.gov/*
- WiCall, Wisconsin's automated voice response system, at 800-947-3544
- Commercial enrollment verification vendors
- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions
- ForwardHealth Provider Services call center at 800-947-9627

Element 9 – Name – Insurance Company
Required. Enter the name of the insurance company.

Element 10 – Address – Insurance Company (Required)
Required. Enter the insurance company's address (street, city, state, and ZIP code).

Element 11 – Name – Policyholder
Required. Enter the policyholder's last name, first name, and middle initial.

Element 12 – Social Security Number – Policyholder
Required. Enter the policyholder's SSN.

Element 13 – Date of Birth – Policyholder
Required. Enter the policyholder's date of birth.

Element 14 – Gender – Policyholder
Required. Indicate the policyholder's gender.

Element 15 – Relationship to Member – Policyholder
Required. Indicate the policyholder's relationship to the member.

Element 16 – Group Number
Required. Enter the group number.

Element 17 – Policy Number
Required. Enter the policy number.

Element 18 – Commercial or Medicare Supplemental Coverage Codes
Situational. Indicate whether the commercial or Medicare Supplemental coverage is drug, major medical physician, dental, inpatient hospital, outpatient hospital, nursing home, vision, durable medical equipment (DME) rental, DME purchase, or home health. Check all applicable options as defined in the following table.

Coverage Code	Definition
Dental	Insurance for dental costs, including the routine preventive care, treatment and care of dental disease, and accidents to teeth.
Drug	Insurance plan that covers all or some of the cost of pharmaceutical medications. Generally these plans are part of a commercial health insurance plan. Insurers can provide these benefits in-house or contract with a Pharmacy Benefit Manger (PBM) to provide these benefits. These plans do not include: discount drug programs or drug coverage associated with Medicare Advantage or Medicare Cost Plans.
DME Purchase	Insurance for medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc., that a plan member can purchase.
DME Rental	Insurance for medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc., that a plan member can rent.
Home Health	Insurance for intermittent home nursing care, home health aide services, various types of therapy, medical supplies, medication prescribed under the home care plan, and nutrition counseling.
Inpatient Hospital	Insurance for the admission to health facilities that provide board and room, for the purpose of observation, care, diagnosis, or treatment. Inpatient care tends to be directed towards more serious ailments and trauma that require one or more days of overnight stay at a hospital. For the purposes of healthcare coverage, health insurance plans require the member to be formally admitted into a hospital for a stay for a service to be considered inpatient.
Major Medical Physician	Insurance for acute care and routine preventive care. This can include primary care visits and specialty care.
Nursing Home	Insurance for medical services rendered by registered or licensed practical nurses, physical therapists, occupational therapists, and speech therapists, for members who have often been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care.
Outpatient Hospital	Insurance for ambulatory care at an outpatient department or clinic without room and board provided, for 24 hours or less. Outpatient care is medical service that does not require a prolonged stay at a facility. This can include routine services such as checkups or visits to clinics. Surgical procedures, so long as they allow the member to leave the hospital or facility on the same day, can still be considered as outpatient care.
Vision	Insurance for routine preventive eye care and prescription eyewear. These plans typically provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery, such as LASIK and PRK.

Element 19 – LTC Coverage Only
Situational. Indicate whether the LTC coverage is LTC Only Cash or LTC Only Claims Reimbursement. Long-Term Care Only Cash describes a policy that pays out a set dollar amount per day when a member cannot perform activities of daily living. Long-Term Care Only Claims Reimbursement describes a policy that requires the submission of a medical claim for reimbursement.

Element 20 – Coverage Start Date
Required. Enter the member's coverage start date. This element is required.

Element 21 – Open-Ended Coverage?
Required. Indicate whether or not the member's coverage is open-ended.

Element 22 – Coverage End Date
Situational. If the member does not have open-ended coverage, enter the member's coverage end date. This element is required if "No" is selected in Element 21.

SECTION III – REPORT INFORMATION

Element 23 – Name – Individual Completing This Report
Required. Enter the name of the individual completing this report.

Element 24 – Date Report Completed
Required. Enter the date the report was completed.

Element 25 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual completing this report.

Element 26 – Name – Source of Information Included on This Report
Required. Enter the name of the individual who provided the information included on this report.

Element 27 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual who provided the information included on this report.

Element 28 – Comments
Enter any additional comments in the space provided.

ATTACHMENT 2
Commercial Other Coverage Discrepancy Report

(A copy of the "Commercial Other Coverage Discrepancy Report" form is located on the following pages.)

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FORWARDHEALTH
COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. All three sections of this form must be completed. ForwardHealth will verify the information provided and update the member's file (if applicable). Refer to the Commercial Other Coverage Discrepancy Report Completion Instructions, F-01159A, for more information. **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.**

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

> ForwardHealth
> Coordination of Benefits
> PO Box 6220
> Madison WI 53716-6220

Allow five to seven business days for processing.

SECTION I – PROVIDER AND MEMBER INFORMATION

1. Name – Provider	2. Provider ID / National Provider Identifier

3. Name – Member (Last, First, Middle Initial)

4. Date of Birth – Member	5. Member ID

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE

6. ❑ Add ❑ Change ❑ Delete	7. Policy Type ❑ Commercial ❑ Medicare Supplemental ❑ Long-Term Care (LTC)

8. Carrier Number

9. Name – Insurance Company

10. Address – Insurance Company (Street, City, State, ZIP Code)

11. Name – Policyholder (Last, First, Middle Initial)

12. Social Security Number – Policyholder	13. Date of Birth – Policyholder

14. Gender – Policyholder ❑ Male ❑ Female ❑ Unknown	15. Relationship to Member – Policyholder ❑ Self ❑ Spouse ❑ Child ❑ Stepchild ❑ Other

16. Group Number	17. Policy Number

Continued

F-01159

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE (Continued)

18. Commercial or Medicare Supplemental Coverage Codes (Check all applicable options.)

- ❏ Dental
- ❏ Drug
- ❏ Durable Medical Equipment (DME) Purchase
- ❏ DME Rental
- ❏ Home Health
- ❏ Inpatient
- ❏ Major Medical Physician
- ❏ Nursing Home
- ❏ Outpatient
- ❏ Vision

19. LTC Coverage Only (Check only one option.)

- ❏ LTC Only Cash
- ❏ LTC Only Reimbursement

20. Coverage Start Date (Required)	21. Open-Ended Coverage? ❏ Yes ❏ No	22. Coverage End Date (Required if Open-Ended Coverage = No)

SECTION III – REPORT INFORMATION

23. Name – Individual Completing This Report	24. Date Report Completed

25. Telephone Number / Extension

26. Name – Source of Information Included on This Report	27. Telephone Number / Extension

28. Comments

(Attach a copy of the applicable insurance card.)

ATTACHMENT 3
Medicare Other Coverage Discrepancy Report Completion Instructions

(A copy of the "Medicare Other Coverage Discrepancy Report Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
MEDICARE OTHER COVERAGE DISCREPANCY REPORT
COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Personally identifiable information about applicants and members is confidential and is only used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the Medicare Other Coverage Discrepancy Report form, F-02074, may result in denial of payment for the services.

Provision of a Social Security number (SSN) is mandatory under the provisions of the Affordable Care Act. The SSN will be used for coordination of benefits purposes. Use or disclosure of any information concerning a policyholder (including a policyholder's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the policyholder (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

> ForwardHealth
> Coordination of Benefits
> PO Box 6220
> Madison WI 53716-6220

Allow five to seven business days for processing.

Type or print clearly. Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System (EVS) and information received from another source. Always complete Sections I and V. Complete Sections II, III, and/or IV as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly.**

INSTRUCTIONS

SECTION I – PROVIDER AND MEMBER INFORMATION

Element 1 – Name – Provider
Required. Enter the provider's name.

Element 2 – Provider ID/National Provider Identifier
Required. Enter the National Provider Identifier (NPI) or Medicaid provider ID of the provider.

Element 3 – Name – Member
Required. Enter the complete name of the member.

Element 4 – Date of Birth – Member
Required. Enter the member's date of birth in MM/DD/CCYY format.

Element 5 – Medicaid Member ID
Required. Enter the member's Medicaid member ID.

Element 6 – Social Security Number
Required. Enter the member's SSN.

Element 7 – Gender
Required. Indicate the member's gender.

Element 8 – Medicare Beneficiary ID Number or Health Insurance Claim Number
Enter the member's Medicare Beneficiary ID number or Health Insurance Claim Number.

SECTION II – MEDICARE PARTS A AND B
Elements 9 and 10 are required if the discrepancy relates to Medicare Parts A or B coverage.

Element 9
Indicate whether Medicare Part A or B is being added, changed, or deleted from the member's insurance.

Element 10
Indicate whether the addition, change, or deletion is for Medicare Part A or Part B.

SECTION III – MEDICARE ADVANTAGE AND MEDICARE COST COVERAGE
Elements 11–19 and 21–22 are required if the discrepancy relates to Medicare Advantage or Medicare Cost coverage. Element 20 is required if the response to Element 19 is No.

Element 11
Indicate whether Medicare Advantage or Medicare Cost is being added, changed, or deleted from the member's insurance.

Element 12
Indicate whether the addition, change, or deletion is for Medicare Advantage or Medicare Cost. Medicare Advantage and Medicare Cost both describe types of Medicare Part C coverage offered by commercial insurance companies to take the place of Medicare coverage for members with Medicare Parts A and B benefits, except for hospice and clinical trials. Medicare Advantage offers this through HMOs, preferred provider organizations, private fee-for-service plans, special needs plans, or Medicare medical saving account plans. For members with Medicare Cost, Medicare covered services received outside the insurance carrier's provider network revert to Medicare Part A or Part B, if the service was not an emergency or obtained with a referral.

Element 13 – Carrier Number
Enter the number associated with the insurance company, found on the EVS.

Element 14 – Name – Insurance Company
Enter the name of the insurance company.

Element 15 – Address – Insurance Company (Required)
Enter the insurance company's address (street, city, state, and ZIP code).

Element 16 – Group Number
Enter the group number.

Element 17 – Policy Number
Enter the policy number.

Element 18 – Coverage Start Date
Enter the member's coverage start date.

Element 19
Indicate whether or not the member's coverage is open ended.

Element 20 – Coverage End Date
If the member does not have open-ended coverage, enter the member's coverage end date. This element is required if "No" is selected in Element 19.

Element 21 – Member Left HMO Service Area
Indicate whether or not the member left the HMO service area.

Element 22 – Date Member Left HMO Service Area
Enter the date the member left the HMO service area if "Yes" is selected in Element 21.

SECTION IV – MEDICARE PART D
Elements 23 and 24 are required if the discrepancy relates to Medicare Part D.

Element 23
Indicate whether Medicare Part D is being added to, changed, or deleted from the member's insurance.

Element 24
Indicate whether or not Medicare Part D coverage is provided through the same Medicare Advantage or Medicare Cost Plan noted in Section III, if applicable.

Element 25 – Carrier Number
Enter the number associated with the insurance company, found on the EVS.

Element 26 – Name – Insurance Company
Enter the insurance company's name.

Element 27 – Address – Insurance Company (Required)
Enter the insurance company's address, including the street, city, state, and ZIP code.

Element 28 – Group Number
Enter the group number.

Element 29 – Policy Number
Enter the policy number.

Element 30 – Coverage Start Date
Enter the member's start date of coverage.

Element 31
Indicate whether or not the member's coverage is open ended. Open-ended coverage means that the policy is active and there is not a termination date.

Element 32 – Coverage End Date
If the response to Element 31 is "no," enter the end date for the member's coverage.

Element 33 – Member Left HMO Service Area
Indicate whether or not the member left the HMO service area.

Element 34 – Date Member Left HMO Service Area
If the response to Element 33 is "yes," enter the date the member left the HMO service area.

SECTION V – REPORT INFORMATION

Element 35 – Name – Individual Completing This Report
Required. Enter the name of the individual completing this report.

Element 36 – Date Report Completed
Required. Enter the date the report was completed.

Element 37 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual completing this report.

Element 38 – Name – Source of Information Included on This Report
Required. Enter the name of the individual who provided the information included on this report.

Element 39 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual who provided the information included on this report.

Element 40 – Comments
Enter any additional comments in the space provided.

ATTACHMENT 4
Medicare Other Coverage Discrepancy Report

(A copy of the "Medicare Other Coverage Discrepancy Report" form is located on the following pages.)

FORWARDHEALTH
MEDICARE OTHER COVERAGE DISCREPANCY REPORT

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. Always complete Sections I and V. Complete Sections II, III, and/or IV as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). Refer to the Medicare Other Coverage Discrepancy Report Completion Instructions, F-02074A, for more information. **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.**

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

ForwardHealth
Coordination of Benefits
PO Box 6220
Madison WI 53716-6220

Allow five to seven business days for processing.

SECTION I – PROVIDER AND MEMBER INFORMATION

1. Name – Provider	2. Provider ID / National Provider Identifier

3. Name – Member (Last, First, Middle Initial)

4. Date of Birth – Member	5. Member ID	6. Social Security Number

7. Gender ❑ Male ❑ Female ❑ Unknown	8. Medicare Beneficiary ID Number or Health Insurance Claim Number

SECTION II – MEDICARE PARTS A and B

9. ❑ Add ❑ Change ❑ Delete	10. ❑ Part A ❑ Part B

SECTION III – MEDICARE ADVANTAGE AND MEDICARE COST COVERAGE

11. ❑ Add ❑ Change ❑ Delete	12. ❑ Medicare Advantage ❑ Medicare Cost

13. Carrier Number

14. Name – Insurance Company

15. Address – Insurance Company (Street, City, State, ZIP Code) (Required)

16. Group Number	17. Policy Number

Note: If the coverage start and end dates are unknown or open-ended, leave Elements 18, 19, and 20 blank and explain the issue in the Comments field of Section V of this form.

18. Coverage Start Date	19. Open-Ended Coverage? ❑ Yes ❑ No	20. Coverage End Date (Required if Open-Ended Coverage = No)

21. Member Left HMO Service Area ❑ Yes ❑ No	22. Date Member Left HMO Service Area (If Applicable)

Continued

SECTION IV – MEDICARE PART D	
23. ❏ Add ❏ Change ❏ Delete	24. Is Medicare Part D coverage provided through Medicare Advantage Plan in Section III? ❏ Yes ❏ No

25. Carrier Number

26. Name – Insurance Company

27. Address – Insurance Company (Street, City, State, ZIP Code) (Required)

28. Group Number	29. Policy Number

Note: If the coverage start and end dates are unknown or open-ended, leave these fields blank and explain the issue in the Comments field of Section V of this form.

30. Coverage Start Date (Required)	31. Open-Ended Coverage? ❏ Yes ❏ No	32. Coverage End Date (Required if Open-Ended Coverage = No)
33. Member Left HMO Service Area ❏ Yes ❏ No	34. Date Member Left HMO Service Area (If Applicable)	

SECTION V – REPORT INFORMATION	
35. Name – Individual Completing This Report	
36. Date Signed	37. Telephone Number / Extension
38. Name – Source of Information Included on This Report	39. Telephone Number / Extension

40. Comments

(Attach a copy of the applicable insurance card.)