UNICARE STATE INDEMNITY PLAN

OTHER HEALTH INSURANCE (OHI) FORM

For UniCare State Indemnity Plan/Basic, PLUS and Community Choice members

UniCare
An Anthem Company

What is this form for?

If you or a family member has health coverage from a health plan other than UniCare, you may need to fill out and send this form to UniCare.

Your UniCare plan has a **Coordination of Benefits (COB)** provision. COB means that UniCare works with the other plan to determine which plan should provide coverage. The COB provision lets you use coverage available from both plans.

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 since then.

You **do** 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 one of these OHI forms before, or the information you provided before needs to be updated.

How do I submit this form?

Fill in the fields below with the requested information. Then, fold the form (so the UniCare address is on the outside) and seal it shut. The form is postage paid, so simply drop the completed form in the mail. If you prefer, you can fax the completed form to 978-474-5162 or email it to contact.us@anthem.com.

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 100 ANDOVER MA

POSTAGE WILL BE PAID BY ADDRESSEE

UniCare State Indemnity Plan
P.O. Box 9016
Andover, MA 01810-0916

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IMPORTANT!
DO YOU HAVE OTHER HEALTH INSURANCE (BESIDES UNICARE)?

Take a look at the instructions to see if you need to complete this form.