JOHNS HOPKINS MEDICINE
US FAMILY HEALTH PLAN

Other Health Insurance (OHI) Form

Please mail completed form to:

Johns Hopkins HealthCare
COB Department
7231 Parkway Dr., Suite 100
Hanover, MD 21076

☐ **No Other Health Insurance**
If you/your family have no other health insurance, please check the box to the left. Please sign your name below and return this form in the enclosed prepaid envelope as soon as possible.

☐ **Commercial Health Insurance**
Please check this box and complete this form if:
A: You or your family members who are enrolled in Johns Hopkins US Family Health Plan **currently** have any other health insurance, OR
B: You had any other health insurance that terminated within the last six months

Policyholder:_____Date of Birth:_____Today's Date: _____

Email:_____ Signature(s): _____

Name (*List member and dependents if applicable*)	Relationship to Policy Holder	Date of Birth	Other Health Insurance Y	N
	Self		☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Please provide the required information about your other health insurance below:

Other Health Insurance Policy #1 (Please print)	
Insurance Company Name	
Insurance Company Address/Phone	
Effective Date of Coverage	
Termination Date of Coverage (if no longer insured by this company)	
Insurance Policy ID Number	
Insurance Policy Group Number	

Subscriber's Name	
Dependents Covered by this Policy (if applicable)	
This policy includes (select one):	☐ Prescription Drug Coverage ☐ No Prescription Drug Coverage ☐ Only Prescription Drug Coverage
Other Health Insurance Policy #2 (Please print)	
Insurance Company Name	
Insurance Company Address/Phone	
Effective Date of Coverage	
Termination Date of Coverage (if no longer insured by this company)	
Insurance Policy ID Number	
Insurance Policy Group Number	
Subscriber's Name	
Dependents Covered by this Policy (if applicable)	
This policy includes (select one):	☐ Prescription Drug Coverage ☐ No Prescription Drug Coverage ☐ Only Prescription Drug Coverage

If you have additional health insurance policies and need another form, you can download and print one at **www.hopkinsusfhp.org/OHI**. *You can also request one by calling Customer Service at 800-808-7347.*

Medicare Part B

If you and/or your spouse have Medicare Part B, please indicate so by checking the box to the right and ☐ list the name(s) of the insured below.

Name:_____ Medicare Number: _____

Name:_____ Medicare Number: _____

The statements made above are true and correct to the best of my knowledge. I understand that Federal Laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries and many beneficiary counseling and assistance coordinators.