Health Plan Survey

Blue Cross Blue Shield of Rhode Island

Member Name: Member ID#:

SECTION 1 – Other Medical Coverage

Besides your BCBSRI coverage, do you have other Medical coverage? Yes ___ No___

If **Yes**, please complete the remaining questions in Section 1. If **No**, please go to Section 2.

Policy holder name: _____

Policy #: _____ Policy effective date: _____

Other carrier name: _____

Other carrier phone #: _____

Other carrier address: _____

If this coverage is provided by an employer, please complete the following questions:

Employer Name: _____

Employer Address: _____

Is the policy holder still working? Yes ___ No___ (If No, provide retirement date: ____/____/_____)

If Yes, select the number of employees: 1-19 ___ 20-99 ___ 100 or more ___ Don't know ___

SECTION 2 – Other Pharmacy Coverage

Besides your BCBSRI coverage, do you have other Pharmacy coverage? Yes ___ No___

If **Yes**, please complete the remaining questions in Section 2. If **No**, please go to Section 3.

Is the pharmacy coverage provided by the same insurer as the Medical coverage above? Yes ___ No___

If **Yes**, please provide RxBIN, RxGroup and RxPCN numbers, then go to Section 3. If **No**, please complete all questions in Section 2.

RxBIN number: _____ RxGroup number: _____ RxPCN number: _____

Policy holder name: _____

Policy #: _____ Policy effective date: _____

Other carrier name: _____

Other carrier phone #: _____

Other carrier address: _____

If your coverage is a supplemental plan, please indicate the type of coverage (e.g., TriCare, Medigap, state pharmaceutical assistance, other)_____

If this coverage is provided by an employer, please complete the following questions:

Employer Name: _____

Employer Address: _____

Is the policy holder still working? Yes ___ No___ (If No, provide retirement date: ____/____/_____)

If Yes, select the number of employees: 1-19 ___ 20-99 ___ 100 or more ___ Don't know ___

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SECTION 3 – Covered Dependents

List other members on your plan that have the other insurance listed above and use an '**X**' to select the applicable coverage.

Last Name	First Name	Date of Birth	Medical	Pharmacy
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Signature_____Date_____

Thank you for your assistance. Please mail this form in the envelope provided or mail to:

OCL Survey-MA - 00199
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

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