FirstCare HEALTH PLANS

Other Insurance Survey

Please take a moment to complete this questionnaire regarding other insurance information for you, your spouse, and your dependent(s). We ask that you update, verify or provide other health care coverage information at least once a year. List and provide information for all members covered under your policy. **If you, your spouse, and/or your dependents don't have other health care coverage, please check the "No other coverage" box below.**

To submit this questionnaire, please do one of the following:

- Update your information on our online Member Self-Service Portal at my.FirstCare.com
- Scan and email the completed form to cservice@FirstCare.com
- Call the customer service number on the back of your FirstCare ID card
- Mail this completed form to:
  FirstCare Health Plans
  P.O. Box 211342
  Eagan, MN 55121-1342

If you have any questions or need additional information, contact us at the customer service phone number on the back of your FirstCare ID card.

FirstCare Member Information	Other Health Care Coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage
Member Name: ______________ Member ID#: ______________	❑ Medicare (complete questionnaire on back) ❑ Medicaid (complete questionnaire on back) ❑ Other (complete questionnaire on back) ❑ No other coverage

Other Health Insurance: If you, your spouse, and/or your dependent(s) are covered by any other policy, please provide the other coverage information below. If other coverage is provided by Medicare or Medicaid, include coverage information under the Medicare or Medicaid section. Duplicate this form, if necessary, to include additional dependent information.

Policy No. 1: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (list covered dependents in box below)

Other Insurance Information:	**Other Coverage Policyholder Information:**
Plan Name:_____ Phone Number:_____	Name: _____
Policy Number: _____Group Number: _____	Relationship: _____
Effective Date: _____ Termination Date: _____	Social Security Number: _____
Is it a retiree policy? ❑ Yes ❑ No	Date of Birth: _____
Is this court-ordered coverage? ❑ Yes ❑ No	List Dependents covered by this policy:
Coverage type (check all that apply):	_____
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental	_____

Policy No. 2: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (list covered dependents in box below)

Other Insurance Information:	**Other Coverage Policyholder Information:**
Plan Name:_____ Phone Number:_____	Name: _____
Policy Number: _____Group Number: _____	Relationship: _____
Effective Date: _____ Termination Date: _____	Social Security Number: _____
Is it a retiree policy? ❑ Yes ❑ No	Date of Birth: _____
Is this court-ordered coverage? ❑ Yes ❑ No	List Dependents covered by this policy:
Coverage type (check all that apply):	_____
❑ Medical ❑ Hospital ❑ Prescription ❑ Dental	_____

Medicare Coverage: Please complete this section if you or your spouse are covered by Medicare.

Policy No. 1: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (Name:_____)

Medicare Policy Number: _____	Current work status: _____
Eligibility due to:	If employed—Company Name:
❑ Age 65 or older ❑ Disability ❑ End Stage Renal Disease	_____
Do you have Part A? ❑ Yes ❑ No Effective Date: _____	If retired—Retirement Date:_____
Do you have Part B? ❑ Yes ❑ No Effective Date: _____	Do you work with another company? ❑ Yes ❑ No
Do you have Part D? ❑ Yes ❑ No Effective Date: _____	If yes—Employer Name: _____

Policy No. 2: This coverage is applicable to: ❑ Self ❑ Spouse ❑ Dependent (Name:_____)

Medicare Policy Number: _____	Current work status: _____
Eligibility due to:	If employed—Company Name:
❑ Age 65 or older ❑ Disability ❑ End Stage Renal Disease	_____
Do you have Part A? ❑ Yes ❑ No Effective Date: _____	If retired—Retirement Date:_____
Do you have Part B? ❑ Yes ❑ No Effective Date: _____	Do you work with another company? ❑ Yes ❑ No
Do you have Part D? ❑ Yes ❑ No Effective Date: _____	If yes—Employer Name: _____

Medicaid Coverage: Please complete this section if you, your spouse and/or dependent(s) are covered by Medicaid.

Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____
Subscriber Name: _____	Dependent Name: _____
Medicaid ID: _____ Effective Date:_____	Medicaid ID: _____ Effective Date:_____

FirstCare™
HEALTH PLANS

If you, or someone you're helping, has questions about FirstCare Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-572-7238 (TTY/TDD 1.800.562.5259).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de FirstCare Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về FirstCare Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Chinese: 如果您或您正在帮助的人士对第一救护健康计划 (FirstCare Health Plans) 有疑问，您有权免费获取对应您母语的帮助及信息。联系口译员请拨打1-855-572-7238 (TTY/TDD 1-800-562-5259)。

Korean: 귀하 또는 귀하가 돕는 있는 사람이 FirstCare Health Plans에 문의할 사항이 있는 경우, 귀하의 언어도 무료 지원 및 정보를 받을 권리가 있습니다. 통역사와 통화하시려면 1-855-572-7238 (TTY/TDD 1-800-562-5259) 번으로 전화해 주십시오.

Arabic:
لك الحق، أو لدى اي شخص آخر تساعده، في الحصول على المساعدة والمعلومات أو اي أسئلة بخصوص FirstCare Health Plans. للتحدث مع مترجم بلغتك
بدون تكلفة اتصل بالرقم 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Urdu:
اگر آپ یا آپ کسی کی مدد کر رہے ہیں, اور سوالات ہیں" FirstCare Health Plans " کے بارے میں, تو یہ آپ کا حق ہے مدد حاصل کرنا اور معلومات حاصل کرنا اپنی زبان میں بغیر کسی قیمت کے.
کسی ترجمان سے بات کرنے کے لئے کال کریں. 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Tagalog: Kung mayroon kang, o sinumang tinutulungan mo, mga katanungan tungkol sa FirstCare Health Plans, mayroon kang karapatang humingi ng tulong at impormasyon nang walang bayad. Upang makipag-usap sa isang tagapagsalin, tumawag sa 1-855-572-7238 (TTY/TDD 1-800-562-5259)

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de FirstCare Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Hindi: यदि आपके, या आप जिन्हें सहायता कर रहे हैं उनके पास FirstCare Health Plans से संबंधित कोई प्रश्न हैं तो आपको अपनी भाषा में बिना किसी शुल्क के सहायता और जानकारी पाने का अधिकार है। किसी अनुवादक से बात करने के लिए यहां कॉल करें 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Persian-Farsi:
اگر شما یا شخصی که به او کمک می‌کنید سوالی درباره FirstCare Health Plans داشتید، این حق را دارید تا کمک و اطلاعات را به زبان خود و بدون هیچ هزینه‌ای دریافت کنید. برای صحبت با یک مترجم با شماره 1-855-572-7238 (TTY/TDD 1-800-562-5259) تماس حاصل فرمایید.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu FirstCare Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-572-7238 (TTY/TDD 1-800-562-5259) an.

Gujarati: જો તમને, અથવા કોઈકને તમે મદદ કરી રહ્યાં છો, તેને FirstCare Health Plans વિશે પ્રશ્નો હોય તો, તમને નિશુલ્ક તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા કોલ કરોઃ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Russian: Если вам или лицу, которому вы помогаете, возникнет вопросы по FirstCare Health Plans, то вы имеете право на бесплатную помощь и информацию на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Japanese: FirstCare Health Plan についてご質問の場合は、無料でご自分の言語のサポートと情報を得ることができます。1-855-572-7238 （テレタイプライター/聴覚障害者用通信機器 1-800-562-5259） にお電話いただき、通訳者とお話しください。

Laotian: ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ກະລຸນາໂທ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Non-Discrimination Notice

FirstCare Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FirstCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free communication aids and services to people with disabilities. We also provide language assistance to people whose primary language is not English.

To receive language or communication assistance please call 1-855-572-7238.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, please contact us to file a grievance:

SHA, LLC dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX 78750
Phone: 1-855-572-7238 *(Mon. - Fri., 8 a.m. - 5 p.m. CT)*
TTY /TDD: 1-800-562-5259

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/filing-with-ocr/index.html

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