OTHER INSURANCE FORM

Client Name: _____

Client Medicaid Number: _____

Insurance Company Name: _____

Insurance Company Address 1: _____

Insurance Company Address 2: _____

Insurance Company Phone #: _____

Policy Holder Name: _____

Policy Number: _____ Policy Holder SSN: _____

Employer Name: _____ Employer Phone: _____

Group Number: _____

Type of Coverage: _____

Ins. Eff. Date: _____ Ins. Term. Date: _____

List any family members that are on the policy: _____

_____

_____

COMMENTS: _____

_____

_____

CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) Fax 1-512-514-4225

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