ALLIED
Benefit Systems, Inc.

PO Box 909786-60690 * Chicago, IL 60690
Tel (312) 906-8080 Fax (312) 261-9363
ADMINISTRATORS AND CONSULTANTS

Other Insurance Verification Form

Employee: _____

Insured's SS _____

Patient: _____

Claim # :
Can be any pended/denied claim number for the patient

Group #: _____

Denied Information Received ☐
Missed Releases ☐
First time Receiving Information ☐

Date: _____

Group Name: _____

Does the above individual or any other family member have other Health Care Insurance coverage?

Yes ☐ No ☐

If yes, and the family member is a spouse, please answer the following....

Spouses Employers Name: _____

Spouses Employers address: _____

_____

Does your spouse have Medical/Dental coverage with this employer? Yes ☐ No ☐

Is your spouse eligible to have Medical/Dental coverage with this employer? Yes ☐ No ☐

Is your spouses coverage single or family coverage? _____

If yes to family coverage - what is the spouses birthdate? _____

If yes: Name , Address and telephone number of insurance.

_____

_____

_____

Spouses Insurance Effective date: _____

*Did your spouse have Medical/Dental coverage with this employer? Yes ☐ No ☐

Spouses Insurance termination date: _____

	Mother	Father
**Which natural parent has court appointed Financial responsibility for children?	☐	☐
**Which natural parent has the court appointed custody of children?	☐	☐

*A letter of credible coverage must be submitted from the previous carrier showing the termination date.
** No divorce decree is required