



## Notification of Other Insurance

Number of pages in fax: \_\_\_\_\_

Please indicate below which health plan the Member is currently enrolled for CHP+:

State Managed Care Network  Denver Health  Colorado Access  Kaiser  Rocky Mountain HMO

### Member Information

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Member # \_\_\_\_\_  
State Id # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State and Zip Code \_\_\_\_\_  
County \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_

### Other Insurance Information

Other Insurance \_\_\_\_\_  
Address \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Policy/Group Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Relationship to member \_\_\_\_\_  
Effective Date \_\_\_\_\_

### Contact Information

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date(s) of Service (if applicable) \_\_\_\_\_

Please fax the completed form to ACS/CHP+ at (303) 893-1780  
Questions? Please call (800) 359-1991  
[www.chpplus.org](http://www.chpplus.org)