



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 Number: _____

Member Id #: _____

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: _____

Email Address: _____

Date(s) of Service: _____

Please fax completed form to (303) 893-1780
Questions? Please call (800) 359-1991 or visit
www.chpplus.org