DHS
Oregon Department of Human Services
Administrative Services
Office of Payment Accuracy and Recovery
Provider Services, Health Insurance Group

Insurance Notification Form

Providers and Plans: Use this form to report information about Medicaid clients *(including Oregon Health Plan)* who are covered by other insurance.

Private Health Insurance

Date: ______________________

Policyholder name: ______________________ Date of birth: ______________

Insurance company name: ______________________ Phone: ______________

Insurance company address: ______________________________

Private health insurance ID number *(include any alpha prefix)*: ______________

Group number: ______________ Policyholder's SSN: ______________

People covered by this insurance *(use additional sheets if necessary)*:

Name	Date of birth	Medicaid case number	Start date	End date	Social Security number

Name of provider or plan submitting this report: ______________________

Contact person: ______________________ Phone: ______________________

Comments:

Please return this form to the DHS Health Insurance Group:

By e-mail: TPR.REFERRALS@STATE.OR.US
by FAX: 503-373-0358
or by mail: P.O. Box 14023, Salem, Oregon 97309-9919

If you have questions, contact the Health Insurance Group at 503- 378-6233 (Salem)

Additional copies of this form are available by going to: http://www.dhs.state.or.us/admin/forms/ and clicking on "Find a Form," then entering "8708"