Other Insurance Form

Insurance Information	
Client Name:	Client Medicaid No.:
Insurance Company Name:	Insurance Company Phone:
Insurance Company Address 1:	
Insurance Company Address 2:	
Policy Holder Name:	Policy Holder SSN:
Policy Number:	
Employer Name:	Employer Phone:
Group Number:	Type of Coverage:
Insurance Effective Date:	Insurance Termination Date:
List any family members that are on the policy:	
Comments:	

Mail completed form to: Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

Or fax to: 512-514-4225

For questions, contact: 800-846-7307