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| **SECONDARY COVERAGE VERIFICATION FORM** | |
| **SECTION A: HEALTH PAYMENT SYSTEMS MEMBER INFORMATION** | |
| Member’s Full Name: | Member’s Employer Name: |
| **SECTION B: PRIMARY INSURANCE INFORMATION** | |
| Name of Primary Insurance Provider: | |
| **\*If Primary Insurance Provider is Health Payment Systems (HPS), please skip to Section C: Secondary Insurance Information below.** | |
| Primary Insured Name: | Effective Date: |
| Insured ID Number: | Group Name/Number: |
| Insurance Provider Address: | Patient Name: |
| **SECTION C: SECONDARY INSRUANCE INFORMATION** | |
| Name of Secondary Insurance Provider: | |
| Secondary Insured Name: | Effective Date: |
| Insured ID Number: | Group Name/Number: |
| Insurance Provider Address: | Patient Name: |
| **Please complete and return this form to: Health Payment Systems**  **c/o Account Care Fax: 414-721-2941**  **735 N. Water Street, Suite 333**  **Milwaukee, WI 53202-4103** | |