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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** |