Pequot Health Care
Pequot Plus Health Benefit Services
Third Party Administration Division
1 Annie George Drive
PO Box 3730
Mashantucket, CT 06338
Phone: 888-779-6872
Local: 860-396-6489
Fax: 860-396-6157

Employee: _____

Patient: _____

Group #: _____

Claim #: _____

Date:

Dear _____:

To complete the processing of the claim(s) for the above-mentioned patient, please provide us with the following information within **forty-five (45) days** of the date of this notice, in accordance with the terms of your health plan*:

INSURANCE UPDATE REQUIRED:
Is there other insurance for child? _____ Yes _____ No

If yes, and it is **not** State aid, is covered through _____ other natural parent _____ step-parent.

Is there a divorce decree or court order which specified coverage? _____ Yes _____ No
If yes, PPHBS requires a copy of that document.

For purposes of determining which plan pays first:
Does the parent carrying the other coverage live with the child? _____ Yes _____ No
Other parent's birth date? _____ Is your spouse employed? _____ Yes _____ No
If yes, name of employer: _____
Was insurance elected? _____ Yes _____ No Covers: ☐ Medical ☐ Dental ☐ Vision
Name of insurance Co.: _____ Effective date: _____
List family members covered under the policy: _____ ,
_____ , _____ , _____

Signature: _____

**** Please be advised that payment of these claims will <u>not</u> be released until the requested information is received. Further, failure to provide this information will result in the denial of your claims rendering you responsible for payment of these charges.***

Please complete, sign and mail/fax your reply to the address/fax number listed above. If you have any questions, please contact Customer Service. Thank you for your cooperation.

Sincerely,
Claims Department

Adjuster: _____