

DEPARTMENT OF BENEFIT PAYMENTS

744 P Street, Sacramento, CA 95814



December 13, 1974

ALL-COUNTY LETTER NO. 74-254

TO: All County Welfare Departments

SUBJECT: Health Insurance Inquiry Mailing

REFERENCE:

On or about the end of this year the Health Recovery Bureau of the Department of Benefit Payments will be mailing a questionnaire to approximately 150,000 persons or families who were beneficiaries of the Medi-Cal Program and for whom the counties had reported other health insurance coverage from January 1972 and forward. The purpose of that mailing is to obtain more detailed health insurance information concerning their coverage.

The health insurance billing process reflects Welfare and Institution Code 10020 et seq. provisions. The process is being computerized in preparation for billing for services provided since 1972 where other health insurance coverage is indicated. This Department will collect funds owed to the Medi-Cal Program by insurance companies and thus reduce the expense to the State.

Current plans include utilization of special toll-free WATTS operators to handle the initial telephone response. Technical questions or those directly related to the questionnaire and/or other health insurance coverage will be answered by Health Recovery Bureau personnel. Non-technical or general welfare questions generated by the mass mailing will be answered by the Department's Public Inquiry and Response Office.

A copy of the proposed questionnaire and cover letter is attached for your information. Should you have any further questions, please contact Jack Gaffney or Dorothy R. Gould at (916) 322-4130 or 322-2280.

DJ Hansen
D. Jerome Hansen, Chief
Health Recovery Bureau

Attachments

cc: CWDA

OBSOLETESuperseded by ACL # 77-15Issued 3-17-77

GEN 654 (2/74)

DEPARTMENT OF BENEFIT PAYMENTS



Your name, address and Medi-Cal eligibility have been obtained from the computerized Medi-Cal program records. These Medi-Cal program records indicate that at sometime since January 1, 1972, you have had health coverage from a private or group health insurance plan which should pay for all or part of your health care.

We are asking you (or a parent or guardian for a minor) to fill out the attached health insurance questionnaire so that our information about your other health benefits is complete and accurate. The State law requires you to provide us with this information.

If you have had other health insurance coverage at any time since you have been eligible for Medi-Cal, please fill out the enclosed form completely. Be sure to examine all the spaces provided and include all the information that is applicable. Sign it in the appropriate spaces and return it in the enclosed postage-paid envelope.

Please complete and return the form to us even though you may have previously furnished this information. It is not necessary for you to send us insurance policies, Medi-Cal identification cards, receipts or any other supporting documents.

If your other health insurance coverage has been cancelled, please fill in the ending date of your coverage in item 12 on the questionnaire. If your other health insurance coverage is still in effect please leave the ending date blank.

If you have never had other health coverage, please mark "NO" on item 1 of the questionnaire, sign and return the questionnaire.

The toll free telephone number listed on the questionnaire will be available from 8:00 a.m. to 10:00 p.m. on normal work days.

Thank you for your assistance.

Sincerely,

D. Jerome Hansen, Chief
Health Recovery Bureau

HEALTH INSURANCE INQUIRY

IMPORTANT: Please complete this form and return it immediately. Write in all eligible family member names, Medi-Cal number, and social security numbers not shown. Put an X in the last column across from any listed person's name who was covered by health insurance since you first received a Medi-Cal card.

1. Yes No Since I/we have been on Medi-Cal, I/we have been covered by a private health insurance policy.
2. Yes No I or a family member has a military connected disability. If Yes, name(s) _____
3. Yes No I or a family member is covered under a life care contract or trust. If Yes, name(s) _____
4. Yes No I or a family member needs or is receiving medical care due to an accident or injury for which another person or insurance company may be liable. If Yes, name(s) _____

I can be called by telephone at the following number _____

BENEFICIARY NAME _____

ADDRESS _____

CITY, STATE _____ ZIP CODE _____

FAMILY MEMBERS:

| NAME | MEDI-CAL NUMBER | SOC. SEC. NUMBER |
|-------|-----------------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| HEALTH INSURANCE INFORMATION | FIRST POLICY | SECOND POLICY |
|--|--------------|---------------|
| 5. Name of Insurance Company | | |
| 6. Address of Insurance Company | | |
| 7. Name of Group, Employer, or Union with Health Insurance | | |
| 8. Address of Group, Employer or Union | | |
| 9. Policy Number or Union Local | | |
| 10. Name of Policyholder or Union Member | | |
| 11. Policyholder or Union Member's Social Security Number | | |
| 12. Date of Insurance Coverage Beginning Date Ending Date | | |
| STATE USE | | |

I hereby assign to the State of California the right to receive all health care coverage benefits to which I may be entitled from any policy or policies of health care coverage issued by the above-named insurance carrier for health care services billed to the Medi-Cal Program. I further agree to indemnify and hold such insurance carrier or other legally designated entity harmless from all liabilities, costs, or expenses incurred as a result of making payment to the State of California pursuant to this agreement.

SIGNATURE OF POLICYHOLDER OR UNION MEMBER _____

DATE _____

Si necesita Ud. más información sobre esta forma, favor de telefonar 1-800-952-5294. No le cuesta nada a Ud. Se habla español.

If you have questions about this form, call us - no charge to you. Dial 1-800-952-5294.