



# Fallon Community Health Plan Third Party Liability Indicator

Date: \_\_\_\_\_

Please complete all fields on form.  
(Please print clearly.)

HEAD OF HOUSEHOLD: \_\_\_\_\_ (LAST, FIRST, MI) SSN: \_\_\_\_\_ TELEPHONE NO.: (\_\_\_\_\_) \_\_\_\_\_

(If you need more space to finish any section on this form, please use the back of this form.)

## 1. MEDICARE INFORMATION

NAME (LAST, FIRST, MI)		CLAIM NUMBER	
PART A	START DATE:	PART A	END DATE:
PART B	START DATE:	PART B	END DATE:

## 2. COMMERCIAL HEALTH INSURANCE INFORMATION

NEW POLICY  
  CHANGE POLICY  
  TERMINATE/CLOSED POLICY  
  ADDITIONAL POLICY  
  POLICY ENDED DUE TO LEAVING JOB

POLICYHOLDER'S NAME (LAST, FIRST, MI):	DATE OF BIRTH:	SSN:	POLICY NO.:
INSURANCE COMPANY NAME:	GROUP NO.:	POLICY START DATE:	POLICY END DATE:
INSURANCE ADDRESS:		INSURANCE TELEPHONE NO.: (      )	
EMPLOYER/UNION NAME:		EMPLOYER/UNION TELEPHONE NO.: (      )	
FAMILY MEMBERS COVERED: NAME:		SSN:	
NAME:		SSN:	
NAME:		SSN:	
NAME:		SSN:	

## 3. ACCESS TO EMPLOYER-SPONSORED HEALTH INSURANCE

IF NOT CURRENTLY INSURED, DOES ANY FAMILY MEMBER'S EMPLOYER OFFER HEALTH INSURANCE?  
 YES  
 NO

EMPLOYER/UNION NAME:	EMPLOYER/UNION TELEPHONE NO.: (      )
EMPLOYER/UNION ADDRESS:	

**Mail or fax this form to:**  
 Susan DiStefano, Senior Claims Manager, Fallon Community Health Plan, 10 Chestnut St., Worcester, MA 01608  
 1-508-368-9198 ■ Fax: 1-508-757-1158