Other Health Insurance (OHI) form

For Total Choice, PLUS, and Community Choice members

If you or a family member have health coverage from a health plan other than Wellpoint, we've made using coverage from both plans more convenient. Your Wellpoint plan has a coordination of benefits (COB) provision. That means Wellpoint works with the other plan to determine which of your plans can provide coverage.

You may need to fill out this and send it to Wellpoint to let us know if you are using more than one plan.

You don't need to fill out this form if:

- Your only health coverage is from Wellpoint, **or**
- Your other health coverage is from Medicare, AARP, MassHealth, or TRICARE, **or**
- Your other coverage is for dental, vision, or life insurance, **or**
- You've filled out this form before and your coverage hasn't changed.

You do need to fill out this form if:

- You have coverage from another health plan (that isn't Wellpoint, Medicare, AARP, MassHealth, or TRICARE), **and**
- You've either never completed an OHI form before or the information you provided needs to be updated.

How to submit the form

You can fill in the fields below, fold the form (with the Wellpoint address on the outside), and seal it shut. The form is postage paid; just drop the completed form in the mail. You can also fax the completed form to **978-474-5162** or email it to **contact.ma@wellpoint.com**.

We are here to help

If you have questions, call Wellpoint Member Services at **833-663-4176** (TTY: 711) or email us at **contact.ma@wellpoint.com**.

Part A: About the Wellpoint enrollee					
Last name	First name	M.I.	Street address		
Wellpoint enrollee ID number			City	State	ZIP code

Part B: About the other health coverage				
Other health plan name			Plan street address	
Plan telephone number			City	State / ZIP code
Name of policyholder	ID number	Group number	Effective date	
Policyholder's relationship to Wellpoint enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (explain)			Are all family members covered under this plan? ☐ Yes ☐ No If no, who is covered?	

I hereby acknowledge that the information I have provided on this form is correct and complete to the best of my knowledge.

Signature **X** _____ Date _____

Claims are administered by Wellpoint Life and Health Insurance Company.
120380MAMENWLP Rev. 05/24

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 49 ANDOVER, MA

POSTAGE WILL BE PAID BY ADDRESSEE

WELLPOINT
PO BOX 4095
WOBURN MA 01888

Wellpoint

If you have other health insurance
(besides Wellpoint)

Please read the instructions to see
if you need to complete this form.