2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
916.563.2250; 888.563.2250 toll free or 711 for TTY
916.568.0126 fax

Dear Member:

At the time of enrollment and periodically thereafter, Western Health Advantage requests information regarding other health care coverage you or your family may have. Complete and return this form to WHA in the self-addressed, postage-paid envelope provided or by fax to 916.568.0126.

Note: If you do not have other health insurance, there is no need to return this form.

If you have any questions, please contact WHA's Member Services department at 916.563.2250 (888.563.2250 toll-free) or TTY 711, Monday through Friday between 8 a.m. and 5 p.m.

Thank you for your cooperation.

Sincerely,

Vanessa Jackson
Manager, Member Services
Western Health Advantage

Name: ______________________ WHA Member ID: ______________________

Please list any other health coverage (excluding dental) that you or any members of your family may have. Other coverage type: ❏ Health ❏ Prescription ❏ Medicare

If Medicare, how did you or your family qualify? ❏ Age ❏ Disability ❏ ESRD

Medicare Health Insurance Claim Number (HICN), if applicable: ______________________

Name of Policy Holder: ______________________ Date of Birth: ______________________

Policy Holder's Employer: ______________________ ❏ Single Coverage ❏ Family Coverage

Name of Insurance Company: ______________________ Policy # ______________________

Effective Date: ______________________ Plan Phone # ______________________

Name(s) of Family Member(s) Covered: ______________________

I certify that, to the best of my knowledge, the information provided above is complete and accurate:

______________________ ______________________
MEMBER SIGNATURE DATE