2d. Name of person carrying other insurance:

3d. Date of Birth
/ /

4d. Member ID:

5d. Name of Other Insurance Carrier:

6d. Policy Number:

7d. Employer Name:

8d. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OF ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.
I CERTIFY THAT THE INFORMATION SUPPLIED IS TRUE AND CORRECT.

Member or Parent/Guardian Signature: Date:

E. ASSIGNMENT OF BENEFITS

1e. Please sign below R Q O \ L I \ R X Z D Q W R & D U H 6 H U Y L F H L W V G L U H F W L Q V W U X F W L R Q V W K H S U R Y L G

Member or Parent/Guardian Signature: Date:

GUIDELINES FOR SUBMITTING CLAIMS TO CareSource

‡ & O L S G R Q R W V W D S O H D O O E L O O V W R C a r e S o u r c e F R P S O H W H G I R U P D Q G P D L O