

SUBSCRIBER THIRD PARTY LIABILITY FORM FOR INSURE OKLAHOMA/O-EPIC

Instructions

Please PRINT or TYPE. Use only BLUE or BLACK ink to complete this form. Failure to provide the information requested may result in your Insure Oklahoma/O-EPIC enrollment being terminated. The TPL form must be signed and dated by the applicant.

For additional assistance or information, call our helpline at **1-888-365-3742** or visit our website at www.insureoklahoma.org. For the hearing impaired, call **(405) 416-6848** (TDD/TTY).

Mail to: **Oklahoma Health Care Authority, Attention: TPL, 2401 N.W. 23rd Street, Suite 1-A, Oklahoma City, OK 73107.**

To maintain accurate records, Insure Oklahoma/O-EPIC requires the following information:

(Make copies of this form as necessary for each health coverage plan)

Applicant and Dependent Information:

Besides Insure Oklahoma/O-EPIC, are you or your dependents enrolled in any other group insurance or benefit plan including Medicare? Yes *(Please complete the information below)* No *(Please sign and mail to the above address)*

Policy Holder's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Policy Holder's Health Insurance Company: _____ Phone: (____) _____

Address _____

Policy #: _____

Group #: _____

Effective Date: (mm/dd/yyyy): ____/____/____

Termination Date: (mm/dd/yyyy): ____/____/____

Coverage: Single Family

Does the plan provide *(check all that apply)*: Medical Pharmacy Dental Vision

Other _____

Please list all persons covered by the policy stated above

Applicant's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

Dependent's Name: Last: _____ First: _____ MI: ____ SSN: ____ - ____ - _____

Date of Birth (mm/dd/yyyy): ____/____/____

The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the State of Oklahoma for any payments or claims incurred which were paid due to my fraud or error. (28 USC 1746)

Signature: _____ **Date:** _____