Status Change Form

CHECK APPLICABLE BOX
❒ TERMINATION
❒ CHANGE

MERCY Health Plans
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INCOMPLETE INFORMATION WILL DELAY PROCESSING YOUR CHANGES AND PRODUCTION OF YOUR MEMBER ID CARD(S)

SUBSCRIBER INFORMATION

CHANGE REQUESTED: ❒ NAME ❒ ADDRESS ❒ PHONE NUMBER ❒ PRIMARY CARE PHYSICIAN ❒ GROUP NUMBER

MEMBER NUMBER	SEX (M F)	LAST NAME	FIRST NAME	M.I.

DATE OF BIRTH (M/D/Y)	STREET ADDRESS
/ /	

CITY	STATE	ZIP	COUNTY

HOME PHONE	BUSINESS PHONE	FAX NUMBER	MARITAL STATUS
			❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED

PREFERRED METHOD OF COMMUNICATION	EMAIL ADDRESS
❒ EMAIL ❒ PHONE ❒ MAIL ❒ FAX	

EMPLOYER NAME	EMPLOYER ADDRESS

FAMILY INFORMATION

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR CHANGES WILL BE DELAYED.
If dependent is a full-time student over age 19, has a last name different from that of the participant, or if dependent is disabled, please attach appropriate documentation from school, courts or physician.

Add or Delete*	MEMBER #	LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH	SEX	ENROLLED IN MEDICARE?	OTHER COVERAGE?	PRIMARY CARE PHYSICIAN (PROVIDER)	PROVIDER I.D. NUMBER
					SELF	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
					SPOUSE	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
					CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
					CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
					CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		

*REASON FOR CHANGE ❒ LAYOFF ❒ RESIGNATION ❒ TERMINATION ❒ DEATH ❒ COBRA ❒ MARRIAGE ❒ DIVORCE ❒ ADOPTION ❒ BIRTH ❒ QMCSO

RELEASE OF INFORMATION

Release of Information Designee:	Relationship	Release of Information Designee:	Relationship

OTHER HEALTH INSURANCE INFORMATION

OTHER GROUP COVERAGE INSURANCE EFFECTIVE DATE _____ MEDICARE EFFECTIVE DATE _____

NAME OF OTHER INSURANCE CARRIER FOR EACH PERSON LISTED ABOVE _____

OTHER CARRIER'S CLAIMS ADDRESS	OTHER CARRIER'S PHONE NUMBER

IMPORTANT INFORMATION

I attest that the information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements made intentionally on this form may render our coverage invalid.

Enrollee:	Spouse:	Date:

EMPLOYER MUST COMPLETE

GROUP # _____ EFFECTIVE DATE OF CHANGE _____

REASON FOR CHANGE ❒ OPEN ENROLLMENT ❒ QUALIFYING EVENT (EXPLAIN) _____

APPROVED BY: DATE

MHP USE ONLY

MHP MO 5215 (07/30/05)	ENTERED BY:	DATE ENTERED