BlueCross BlueShield of Texas

Dependent Addition and Change Form for Court-Mandated Health Coverage
Complete In Ink - Please Print

❑ Addition ❑ Change (see reverse side)

Group No.	Section No.	Member Identification No. (Medical)	Member Identification No. (Dental)	Payroll No.

Employee's Last Name	First	Middle

Home Address No. and Street Name	City	State	ZIP	Phone No.

Custodial Parent's Last Name	First	Middle

Home Address No. and Street Name	City	State	ZIP	Phone No.

State Agency Name	Agency No.	Date Employer Received Order	Phone No.

State Agency Address No. and Street Name	City	State	ZIP

Complete all information for each dependent being added.
Effective 1-1-96: Health care companies in Texas are required to follow special procedures in situations where a natural or adoptive parent (or legal guardian) is required by a court to provide health coverage for a child.
A copy of the court or administrative order or decree must accompany this form.

List the Full Name of All Dependents To Be Covered	Social Security No.	Date of Birth Mo/Day/Yr	PCP/PCD Name HMO only	PCP/ PCD#	Are You a New Patient?
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No

Previous Coverage Information Complete only if applying for coverage other than HMO or In-Hospital Indemnity

In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.) If Medicare, please complete the Medicare coverage Information Section below.

List names of every individual covered: _____

Primary Enrollee	Date of Birth / /	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy Number	ID Number

Employer's Name: Name and address of other health care company, TPA, HMO	Employment Date ___/___/___ Effective Date ___/___/___ Will coverage be continued? ☐ Yes ☐ No If No, Expected Cancel Date ___/___/___	Type of Coverage ☐ Health ☐ Dental ☐ Employer Sponsored OR ☐ Individual Purchase	Type of Policy ☐ Self ☐ Family ☐ Employee/Spouse ☐ Employee/Child

Are any of the above dependents covered by any other health or dental coverage? ❑ Yes ❑ No If yes, please check the applicable boxes below and list the effective date for each coverage checked and complete the remainder of this section.

❑ Health ❑ Dental ❑ Group ❑ Individual ❑ Medicare Part A (Hospital) Eff. _____ /_____ /_____
Eff. _____ /_____ /_____ Eff. _____ /_____ /_____ ❑ Medicare Part B (Medical) Eff. _____ /_____ /_____

Please check the reason for Medicare eligibility: ❑ Entitled Disability ❑ End Stage Renal Disease ❑ Disability and Current Renal Disease

Name and Address of Other Health Care Co.	ID/Medicare Number	Group or Policy No.

Employer's Name	Name of Primary Enrollee	Date of Birth / /	❑ Male ❑ Female	Relationship To Applicant ❑ Spouse ❑ Dependent

As a supplement to my previous application, I request the change(s) in coverage to include dependents listed above.

_____ X_____
Date Signature Relation to Dependent

Home Phone Number (_____) _____

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

Change Form For Court-Mandated Health Coverage
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Group No.	Section	Member Identification No. (Medical)	Member Identification No. (Dental)	Payroll No.

Employee's Last Name	First	Middle

Home Address No. and Street Name (Complete only if address has changed)	City	State	ZIP	Phone No.

Custodial Parent's Last Name	First	Middle

Home Address No. and Street Name	City	State	ZIP	Phone No.

State Agency Name	Agency No.	Phone No.

State Agency Address No. and Street Name	City	State	ZIP

Complete all information for the change to each existing dependent

Please check the applicable box(es), show date:

❑ Cancel dependent coverage_____ ❑ Change of Address - listed above. ❑ Deceased _____

❑ Married _____ ❑ PCP/PCD Change _____ ❑ Other _____

List The Full Name of All Dependents To Be Covered	Social Security No.	Date of Birth Mo /Day/Yr	PCP/PCD Name	PCP/PCD#	Are You a New Patient?
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | | |	/ /			❑ Yes ❑ No
Last First Middle ❑ Son ❑ Daughter	| | |–| | |–| | |	/ /			❑ Yes ❑ No

As a supplement to my previous application, I request the change(s) in coverage to include dependents listed above.

_____ X_____

Date Signature Relation to Dependent

Home Phone Number (_____) _____

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Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.

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