Third Party Liability Indicator



Instructions

- 1. Complete Step 1: Head of Household information.
- 2. Complete Step 2: Third Party Liability information updates.
- 3. Return the form to Fallon Health by fax or mail.

u must complete th	is section.)		
Last, First, Middle initial			
al Security Numb	er (SSN):		
ete the section that	you need Fallon Healtl	h to update.)	
r mation (Comple n.)	te only if you need F	allon Health to	
e/Close Policy			
Policyholde	Policyholder's Date of Birth:		
Policy Number:			
Group Nur	Group Number:		
Policy End	Policy End Date:		
Insurance -	Insurance Telephone Number:		
		(XXX) XXX-XXXX	
Date of Birth	Fallon Health ID N	umber or SSN	
	Last, First al Security Number ete the section that mation (Comple .) e/Close Policy Policyholde Policy Num Group Num Policy End Insurance	Last, First, Middle initial al Security Number (SSN): ete the section that you need Fallon Health fimation (Complete only if you need Fallon) e/Close Policy Policyholder's Date of Birth: Policy Number: Group Number: Policy End Date: Insurance Telephone Number:	

information.)	ete only if you need Fallon Health to update Medicare insurance
Name:	Medicare Beneficiary Identifier (MBI) Number:
Last, First, Middle initial	
Part A:	
☐ Add Policy Start Date:	End Date:
☐ Close Policy Start Date:	End Date:
Part B:	
☐ Add Policy Start Date:	End Date:
☐ Close Policy Start Date:	End Date:
Part C:	
Note: Part C plans are commonly known ☐ Add Policy Start Date:	- 1
Insurance Carrier:	Plan Name:
☐ Close Policy Start Date:	End Date:
Insurance Carrier:	Plan Name:
Part D:	
☐ Add Policy Start Date:	End Date:
Insurance Carrier:	Plan Name:
☐ Close Policy Start Date:	End Date:
Insurance Carrier:	Plan Name:
Step 3: Return the completed form to 1. Fax: 508-368-9890 2. Mail: Fallon Health Attn: COB	Fallon Health in one of these ways:

Questions?

PO Box 211308

Eagan, MN 55121-2908

Call Fallon Health Provider Services at (866) 275-3247, opt. 4