ABS Automated Benefit Services

AUTOMATED BENEFIT SERVICES, INC.

For your convenience we have 4 easy ways to submit this information:

1. Scan and email to ACMHO-MB-CORP2@ABS-TPA.COM
2. Or Mail to: Automated Benefit Services
   P.O. Box 37506 Oak Park, MI 48237-0506
3. Or fax to: 586-693-4321
4. Or call and provide to Customer Service at 1-844-501-3466

REQUEST FOR OTHER INSURANCE INFORMATION

Please take a moment to complete this questionnaire regarding other coverage information for you and your dependents. **If you have questions about this form, please call Customer Service at (844) 501-3466.**

Do you or any of your covered dependents have other coverage? Yes ☐ No ☐ Member ID ☐

If NO, please sign, date and return the form to the address listed above. If YES, complete the following:

Name	Relationship to Associate	Address (if different from Associate)	Other Coverage (Name of Carrier or Medicare or COBRA) DO NOT INCLUDE MEDICAID	Type of Coverage Medical, Dental or Vision	Effective Date of Coverage

If Other Coverage on any minor child above and their parent is not already listed as one of your dependents and parents are living together or parents have joint custody, please provide the following:

Mother	Name:	Date Of Birth: / /
Father	Name:	Date Of Birth: / /

If parents of the minor child are separated or divorced or not living together, please complete the following:
Is there a court order making one parent responsible for the child's medical expenses? YES ☐ NO ☐
Please enclose a copy of the court order with this form and return to the address above.

	Mother	Father
Name of parent responsible for the child's medical expenses		
Name of parent with physical custody of the child		

Associate's Signature _____ Date Completed _____ ( ) Phone Number _____ Email Address _____ *Please notify ABS if any of the above information change*