PAYEE MEDICAL SUPPORT QUESTIONNAIRE

Date: ____________________
Case Number:
_____________Worker ID:
____
Children:
____
____
____
____
____
____

____
____
____
____

Dear Payee:

The Child Support Recovery Unit (CSRU) is responsible for gathering health care coverage information for the child(ren) listed above. The information is needed to establish and enforce medical support.

Please complete and return in 10 working days. **Mail or fax it to:** Child Support Recovery Unit
____
____
____
FAX #: __________________

Medical Support Information

Is a health benefit plan available to the child(ren)? ☐ Yes ☐ No

If yes, who is enrolled: ☐ Self ☐ Spouse ☐ Child(ren) (number of children)____ ☐ None

Is the coverage: ☐ Medicaid (Title 19) ☐ HIPP ☐ *hawk-i* ☐ Employment-related ☐ Other

What is the monthly cost of a family plan $ ________________
What is the monthly cost of a single plan $ ________________

If *hawk-i* coverage, what is your monthly cost $______________

Is there a support order that requires medical support be provided? (Medical support may include a health benefit plan, payment of medical bills, a cash amount for medical bills, etc.) ☐ Yes ☐ No

If yes, list: Court Order Number: ______________________________
Place Order Filed - County/State/Tribe: __________________
Date Order Entered: _________________________________

Is a health benefit plan available to the child(ren)'s other parent? ☐ Yes ☐ No ☐ Unknown

If yes, are the child(ren) enrolled? ☐ Yes ☐ No Date coverage available: _______________

What is the monthly cost of a family plan? $ ________________
What is the monthly cost of a single plan? $ ________________

If the child(ren) currently have a health benefit plan, please also complete the following pages.

Health Care Coverage Section

Name of person providing the health benefit plan:____________________________

Dependent Name(s): ______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Major Medical	
Policy Number:	Effective Date:
Insurance Company Name:	Contact Name/Phone Number:
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

Prescription Drugs	
Policy Number:	Effective Date:
Insurance Company Name:	Contact Name/Phone Number:
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

Vision	
Policy Number:	Effective Date:
Insurance Company Name:	Contact Name/Phone Number:
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

Dental	
Policy Number:	Effective Date:
Insurance Company Name:	Contact Name/Phone Number:
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

Other	
What is the type of plan?	
Policy Number:	Effective Date:
Insurance Company Name:	Contact Name/Phone Number:
Claims Address/Phone Number:	
What is the monthly cost of a family plan?	
What is the monthly cost of a single plan?	

Signature:	Date:

Worker ID: ___________________