

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
Cost Avoidance Unit
P.O. Box 182410
Columbus, OH. 43218-2410

Date: 06/24/04

92405
ANTHEM BLUE CROSS/BLUE SHIELD
P O BOX 37180

LOUISVILLE, KY 40233

Policyholder: DOE JOHN
Policyholders SSN: 123-45-6789
Policy # ABC123456789
Group # 01010

In order for office to process your response please reference our Cost Avoidance Administrative # and / or Member I.D. Numbers. When processing your automated Response, please attach this document before mailing.

Provide the mailing address & phone numbers for claims & policy verification :
Claims Processing

Name _____
Add. _____
City _____ St. _____ Zip _____
Phone no. () _____

Policy Verification

Name _____
Add. _____

When reviewing your records, complete the following & make any needed changes.

Policyholder's name _____
Policy # _____
Policyholder's SSN _____
Group # _____
Phone no. () _____

Employer _____
Add. _____
City _____ St. _____ Zip _____

The following is a list of individuals whom we show as having coverage with your company. If we have omitted anyone that is currently listed on your files please write in the additional information.

C.A.Administrative #	Member Name	I.D.	BEGIN/END DATE
5009999999	DOE JOHN	102888888899	
5009999999	DOE JANE	102777777799	
5009999999	DOE BAMBI	102666666699	

Please list benefits included in this plan, such as, but not limited to :

Transport Physicians Inpatient Out Patient Nursing home Drugs/Pharmacy

COUNTY# 25

DOCUMENT#

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Dear Insurance Carrier:

We have been aware that the individual(s) named on the reverse side may have an active or recently closed health insurance policy with your company.

Under Section 42(CFR)4331.305 of the Federal Code of Regulations requires Medicaid information that must be safeguarded to include; (1)names and addresses; (2)medical services provided; (3)social and economic conditions or circumstances; (4)agency evaluation of personal information; (5)medical data, including diagnosis and past history of disease or disability; (6)information received for verifying income and amount of medical assistance payment; and (7) information received in connection with the identification of a third party resource.

Also Under Section 5101.572 of the Ohio Revised Code(ORC) any information provided shall not be considered a violation of any right of confidentiality or contract the Third Party may have with covered persons including subscribers.

We are requesting that your office complete the questionnaire on the reverse side of this letter to verify health insurance coverage and return it in the self addressed enclosed envelope to the Ohio Department of Job and Family Services.

If you are using an automated system to respond to inquiries, please include our Cost Avoidance Administrative numbers or the identification numbers listed on the reverse side of this letter. If at all possible return this letter with your response.

We would appreciate your timely response in providing us with the information requested. If not an automated system please forward this letter in the enclosed postage paid envelope.

Sincerely,

Cost Avoidance Unit