OptimaHealth

OUT OF AREA DEPENDENT CHILD NOTIFICATION

This dependent child notification form for out-of-area dependents is required when dependent children live outside the service area.

TO ASSURE ACCURATE CLAIMS PAYMENT, THIS FORM MUST BE COMPLETED AND MAILED TO:
OPTIMA HEALTH
ATTN: ENROLLMENT DEPT.
4417 CORPORATION LANE
VIRGINIA BEACH, VA 23462

Group No. _____ **Group Name**:_____**Member No**. _____

Eff. Date of Coverage: _____ PRODUCT: **HMO**

YOUR COMPLETE NAME **SOCIAL SECURITY NUMBER**

_____ _____
Last Name First MI

Enter the names(s) and address(es) of your eligible dependents out-of-area:

Dependent 1
Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____

Dependent 2
Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____

Dependent 3
Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____