Coordination of Benefits Questionnaire

BCBS POLICYHOLDER NAME: _____

BCBS GROUP #: _____

BCBS MEMBER ID #: _____ _____

Your Blue Cross Blue Shield contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's Blue Cross Blue Shield plan immediately.

OTHER INSURANCE:

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

☐ No If *No*, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ Yes If *Yes*, please complete all the fields below that pertain to the member(s) that has the other coverage.

Section A *If this does not apply, skip to Section B.*

Check those that apply:

☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this?

☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Dependent(s) listed on the other insurance: _____

_____

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth: ____/____/_____ ID # _____

Effective Date of Other Insurance: ____/____/_____ If Cancelled, Cancellation Date: ____/____/_____

Is the policyholder:

☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: ____/____/_____

☐ On COBRA, which began: ____/____/_____

Policyholder's Employer: _____

Employer's Address: _____

City, State, & Zip: _____

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Section B *If this does not apply, skip to Section C.*

MEDICARE INFORMATION

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare: _____

Medicare Number, including alpha character(s): _____

Effective Date of Medicare Part A ____/____/_____ Effective date of Medicare Part B: ____/____/_____

Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: ____/____/_____

1st Date of Dialysis for ESRD: ____/____/_____

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If *yes*, please provide the date of the transplant. ____/____/_____

Section C *If this does not apply, skip to Section D.*

COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ No ☐ Yes

List the name(s) of the dependent(s) that this applies to. _____

If yes, who is the person(s) listed to maintain health coverage? _____

What is the relation to the child(ren)? _____

Who has custody of the child(ren) more than 50% of the time? _____

Documentation of the court order may be requested from your Blue Cross Blue Shield plan.

Section D

NAME(S) OF DEPENDENT(S) ON BCBS POLICY

Name	Relationship	Date of Birth	Sex	Social Security # (Optional)
_____	_____	____/____/_____	_____	_____-_____-_____
_____	_____	____/____/_____	_____	_____-_____-_____
_____	_____	____/____/_____	_____	_____-_____-_____

Policyholder Signature: _____ **Date:** ____/____/_____