



Coordination of Benefits Questionnaire

BCBS POLICYHOLDER NAME: _____

BCBS GROUP #: _____

BCBS MEMBER ID #: _____

Your Blue Cross Blue Shield contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by Blue Cross Blue Shield in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply.

OTHER INSURANCE:

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

- No If No, please complete Section A, 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

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

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

Policyholder Signature: _____ Date: ___/___/___

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

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: Effective or Cancel Date, if different from policyholder:

_____	___/___/___
_____	___/___/___
_____	___/___/___



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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: _____

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

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: ____/____/____

Effective Date of Medicare Part D ____/____/____

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 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.