

## **COORDINATION OF BENEFITS QUESTIONNAIRE**

This form **MUST** be completed to notify MedPartners Administrative Services of Medicare or other health insurance coverage for Coordination of Benefits (COB). **FAILURE TO COMPLETE THIS FORM WILL RESULT IN DELAYS TO CLAIM PAYMENTS**.

PLEASE CHECK REASON FOR	SUBMI	ISSION:						
<ul><li>☐ Annual COB update</li><li>☐ Ne</li><li>☐ Add dependent/spouse</li></ul>	ew enro	ollee 🗆 /	Add other	r insura	nce 🗆	Termination	on of oth	ner insurance
Group Policy#	G	roup or Emp	oloyer Nar	me _			· · · · · · · · · · · · · · · · · · ·	
Member ID #	M	ember/Emp	me		· · · · · · · · · · · · · · · · · · ·			
Address		Phone #						
ARE YOU OR ANY OF YOUR CO	OVERE	D DEPEND	ENTS AL	so cov	/ERED B	Y ANOTHE	R GROL	JP HEALTH PLAN?
<ul><li>□ NO – Please skip the rest of</li><li>□ YES – Complete entire form,</li></ul>	•	nd return.		·				
						licare So	Contin	n 3)
SECTION 1 OTHER HEALTH (	COVER	AGE INFO	RMATION	(Exclu	ding Med	licare – See	Section	
Please provide information abo	ut polic	cy holder o	f the othe	r health				· ·
Please provide information abo	ut polic			r health		ge. Attach		· ·
Please provide information abo  Name of policy holder of other coverage	ut polici Relatio	cy holder o	f the othe Social Sec	r health	coverag	ge. Attach		nal pages if needed.
Please provide information abo Name of policy holder of other coverage Insurance company name	ut polici Relatio	onship to you nice company a	f the othe Social Sec	r health	Employer	ge. Attach	addition	Birth date
Please provide information abo Name of policy holder of other coverage Insurance company name Member ID/Policy #	Relatio Insurar Group	onship to you nice company a	Social Sec	er health curity #	Employer	ge. Attach	Cancel	Birth date  Phone #
SECTION 1 OTHER HEALTH (  Please provide information abo  Name of policy holder of other coverage  Insurance company name  Member ID/Policy #  Type of coverage:   Single  Fan  Who is covered by this other plan? Include	Relation Insurar Group	cy holder of onship to you nice company a	Social Sec	er health curity #	Employer e date	ge. Attach	Cancel	Birth date  Phone #  Date of the control of the con
Please provide information abo  Name of policy holder of other coverage  Insurance company name  Member ID/Policy #  Type of coverage:   Single   Fan	Relatio Insurar Group nily e yourself	cy holder of onship to you nice company a	Social Sec	er health curity # Effectiv	Employer e date	ge. Attach	Cancel	Birth date  Phone #  Date of the control of the con
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SECTION 2 SPECIAL SITUATIONS FOR DEPENDENT CHILDREN												
Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation, etc.												
Is there a court order that determines responsibility for health care coverage or custody?												
□ No □ Yes – Attach copy of applicable section pertaining to custody and/or health care coverage.												
Who does the court order indicate is responsible for insurance/health coverage?												
Person responsible for child's health care coverage	Social Security #	Relationship	Employer		Birth date							
Insurance company name	Insurance company address			Phone	<u> </u> #							
Member ID/Policy #	Group #	Effective date		Cancellation date								
Which children are covered by this insurance?												
Child's Name (First and Last) Who h	Child's Na	me (First and Last)	Who has custody?									
1	<del> </del>		<del></del>									
2 5												
3 6												
SECTION 2 MEDICARE COVERAGE												
SECTION 3 MEDICARE COVERAGE  If you ar your should has Madicare coverage, please complete the following:												
If you or your spouse has Medicare coverage, please complete the following:  Are you covered by Medicare? □ No □ Yes □ Actively Employed □ Retired												
Reason for coverage:   Over 65   Disabled  ESRD (End Stage Renal Disease)												
Hospital Part A: Effective Date			,									
Hospital Part B: Effective Date												
Is your spouse covered by Medicare? □ No □ Yes □ Actively Employed □ Retired												
Reason for coverage:   Over 65 Disabled ESRD (End Stage Renal Disease)												
Hospital Part A: Effective Date												
Hospital Part B: Effective Date												
MEMBER'S SIGNATURE DATE												
Return completed form to: MedPartners Administrative Services OR Fax to: (260) 435-7513												

P.O. Box 2602 Fort Wayne, IN 46801