

Coordination of Benefits Questionnaire



BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):
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Policyholder Name:	
Group Number:	Member ID Number with Three Letter Prefix:

Section **A** Other Insurance

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or 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.

Mark 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

Address	State	Zip	Phone Number
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Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name	Policyholder's Date of Birth	ID Number
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Effective Date of Other Insurance If Cancelled, Cancellation Date

Is the policy holder: Actively working for the group Inactive
 Retired, retirement date: _____ On COBRA, which began: _____

Policyholder's Employer

Address

City	State	Zip	Phone Number
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Section B**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: Yes Disability* Yes 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**Court Order Information**

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

Yes No

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 and/or Blue Shield Plan

Section D**Names of Dependent(s) on Blue Cross and/or Blue Shield Policy**

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder Signature

Date