

Coordination of Benefits Questionnaire



- **Provider:** After the policy holder has completed and signed, please forward this form to your local BlueCross and/or Blue Shield Plan immediately. **Do not hold to submit with the claim.** Completed forms may be faxed to BCBST at (423) 535-1959.
- **Member:** 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.

Please send this completed form to the BCBS Plan that you are a member of.

You can call the customer service phone number on your membership ID card to get the address.

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

Section A

Other Insurance *If this does not apply, skip to Section B*

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.

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

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name Policyholder's Date of Birth ID Number

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 |

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

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 of 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 *If this does not apply, skip to Section D*

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 Blue Shield Plan

Section D Names of Dependent(s) on BCBS Policy

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

Policy Holder Signature

Date