of Tennessee
plans for better health. plans for a better life.™

Coordination of Benefits
1 Cameron Hill Circle Ste 0034
Chattanooga, Tennessee 37402-0034

bcbst.com

COB Questionnaire

❑ **No, I and/or my covered dependents do not have other health or dental insurance.**
You may call us toll-free at 1-800-200-3704. Please follow the instructions and provide all the information requested. Or, you may sign and date the bottom of this form and return to the above address.

❑ **Yes, I and/or my covered dependents do have other health or dental insurance.**
Please complete this form and return to the above address. List all other insurance coverage (other than the policy listed on the attached letter) including other BlueCross BlueShield coverage.

If you also have Medicare, please complete the Medicare Coverage Information form. If you have more than two policies, please call Member Service at 1-800-565-9140 between 8 a.m. and 5:15 p.m. ET, Monday through Friday.

OTHER MEDICAL INSURANCE INFORMATION (Non-Medicare)

Member Name	Member's Date of Birth	Identification Number
Name of Other Insurance	Policy Effective Date	Policy Cancel Date (if applicable)
Employer's Name	Employer's Telephone Number	Other Insurance Company Telephone Number

This coverage is: ❑ Employer Group Policy or, a ❑ Non-Group Policy

This policy covers: ❑ Member Only, ❑ Member + one dependent, or ❑ Family

Please list all members covered under this policy, including you. Give the member's relation to the other policyholder (example: spouse, child, stepchild, or other). Specify if the other policyholder covers any child(ren) as a guardian or per a court order.

First Name	Last Name	Relationship/guardianship/ court order

Please check all categories that describe the covered benefits:

❑ Hospital/Medical/Surgical ❑ Vision ❑ Mental Health

❑ Prescription Drugs (for copay please list copay amounts: Brand $_____ Generic $_____)

❑ Other (please describe) _____

Identification Number:
Group Number:
Subscriber Name:
Daytime Phone Number (_____)_____
Home Phone Number (_____)_____

Please sign and date:
I certify to the best of my knowledge that the above information is true and correct.

_____ _____
Member's Signature Date

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Confidential—this information is intended for the use of the specific individual or entity named above.