of Tennessee

Coordination of Benefits Questionnaire

- **Provider:** After the policy holder has completed and signed, please forward this form to your local BlueCross and/or BlueShield Plan immediately. Do not hold to submit with the claim. Completed forms may be faxed to BCBST at (423) 535-1959.
- **Member:** Your BlueCross BlueShield 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 policy holder's BlueCross BlueShield 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 BlueCross BlueShield policy covered by another medical or dental insurance policy, any other BlueCross BlueShield 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	State	Zip	Phone Number
Dependent(s) Listed on the Other Insurance			
Other Insurance Policy Holder's Name	Policyholder's Date of Birth	ID Number	
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			
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 BlueCross BlueShield Plan

Section D

Names of Dependent(s) on BCBS Policy

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