BlueCross BlueShield of Illinois
BlueCross BlueShield of New Mexico
BlueCross BlueShield of Oklahoma

Coordination of Benefits Questionnaire

BCBS POLICYHOLDER NAME:

BCBS GROUP #:

BCBS MEMBER ID #:

Your Blue Cross and Blue Shield contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by Blue Cross and Blue Shield in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply.

OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)

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

- ❑ No If *No,* please make any revisions necessary to the information in Section A, sign, date and return this questionnaire to us, indicating No other insurance."
- ❑ Yes If Yes, please make any revisions necessary to the information in Section A and complete all the fields below that pertain to the member(s) that has the other coverage.

Section A

NAME(S) OF DEPENDENT(S) ON BCBS POLICY

Name	Relationship	Date of Birth	Sex	Social Security # (Optional)
		/ /		
		/ /		

Signature Required: **Date:**

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

Check those that apply: ❑ Other Health Insurance ❑ Other Dental Insurance

What type of policy is this? 1:1 Group ❑ Individual Policy ❑ Student Policy ❑ Medicare Supplemental

Other Insurance Carrier's Name: (If more than one, list on separate page)

Address:

City, State, Zip: Phone Number:

Dependent(s) listed on the other insurance: Effective or Cancel Date, if different from policyholder:

/ /

Other Insurance Policyholders Name:

Policyholder's Date of Birth: / / ID #

Effective Date of Other Insurance: Is / / If Cancelled, Cancellation Date: / /

the policyholder:

❑ Actively working for the group ❑ Inactive ❑ Retired, retirement date: / /

❑On COBRA, which began: / /

Policyholder's Employer:

Employer's Address:

City, State, & Zip:

Section C *If this does not apply, skip to Section D.*

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: / /

Effective Date of Medicare Part C / / Effective Date of Medicare Part D / /

Medicare Entitlement: ❑ Age ❑ Disability* ❑ 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. / /

In addition, please provide a copy of the Medicare Card

Section D

COURT ORDER INFORMATION

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

❑ No ❑ Yes

List the name(s) of the dependent(s) to whom the Court Order applies: 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 Blue Shield plan.