



# Coordination of Benefits Questionnaire

BCBS POLICYHOLDER NAME: \_\_\_\_\_

BCBS GROUP #: \_\_\_\_\_

BCBS MEMBER ID #: \_\_\_\_\_

Your Blue Cross Blue Shield contract contains a Coordination of Benefits (COB) provision. This form is required by Blue Cross 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 call the number found on the back of the identification card. We appreciate your prompt reply.

## OTHER INSURANCE:

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

- No If No, please complete Section D, print, sign, date and return this questionnaire to Blue Cross and Blue Shield of Texas, P.O. Box 660044, Dallas, TX 75266-0044, indicating "No other insurance."
- Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other Coverage, print and return to:  
Blue Cross and Blue Shield of Texas, P.O. Box 660044, Dallas, TX 75266-0044,

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

Check 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: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other Insurance Policyholder's Name: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ ID # \_\_\_\_\_

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: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_



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

### 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 D \_\_\_/\_\_\_/\_\_\_

Medicare Entitlement:  Age  Disability\*  End Stage Renal Disease (ESRD)\*

\* If the reason is for Disability or ESRD, please provide the following:

1<sup>st</sup> Date of Disability: \_\_\_/\_\_\_/\_\_\_

1<sup>st</sup> 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 *If this does not apply, skip to Section D.*

### COURT ORDER INFORMATION

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

No  Yes

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

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

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

Policyholder Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_