Coordination of Benefits Questionnaire: Out of Area Members

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Please fax or mail this form to the following:

1901 Market Street
Philadelphia, PA 19103
Fax: 215-238-7915

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name | NPI (Give Tax ID if No NPI Number)

Policyholder Last Name | Policyholder First Name

Group Number | Member ID Number with Three Character Prefix **(Must Include Plan Prefix)**

Section A — Other Insurance *If this does not apply, check No and 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, check No and 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, check No and 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**