

Coordination of Benefits Questionnaire

S115

Your Blue Cross Blue Shield 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 policyholder's Blue Cross Blue Shield plan immediately.

	The second contract of the contract of the second s	orm to the BCBS Plan that you a ce phone number on your membe		address.		
BCBS Policyholde	er Name		¥1			
BCBS Group Num	nber		BCBS Member ID Number			
Section A	Other Insura	nce If this does not apply, skip to Sect	ion B.			
		f this Blue Cross Blue Shield polic e Shield policy or Medicare?	y covered by another m	nedical or dental insurance		
	o, please complete other insurance."	Section D, sign, date and return t	his questionnaire to us	indicating		
Yes If Ye	es, please complete	all the fields below that pertain to	the member(s) that has t	he other coverage.		
Mark tho	ose that apply:	Other Health Insurance	Other Dental Insurance			
What typ	pe of policy is this?	Group Individual Policy	Student Policy	Medicare Supplemental		
Other Insurance C Address City	Carrier's Name	State	Zip	Phone Number		
		State	2.10	Thore Number		
Dependent(s) liste	ed on the other insurance	9	, ,	1		
Other Insurance P	Policyholder's Name	7	Policyholder's Date of Birth	ID Number		
1	1	1 1				
Effective Date of 0	Other Insurance	If Cancelled, Cancellation Date				
Is the policyh	nolder: Actively	working for the group	Inactive			
ľ	Retired,	retirement date:/ /	On COBRA, which be	gan:/_/		
Policyholder's Em	nployer					
Address		<u> </u>	Ī			
City		State	Zip	Phone Number		

Name Relationship Date of Birth Sex Social Security Number (Optional	Section B	Medicare Inform	icare Information If this does not apply, skip to Section C.						
Medicare Number, including alpha characteris) Effective Date of Medicare Part A:	Do the policy	holder and/or depende	nt(s) have Medicare	e? Yes N	0				
Medicare Number, including alpha characteris) Effective Date of Medicare Part A:									
Effective Date of Medicare Part A:	Name of person(s	s) with Medicare							
Medicare Entitlement:	Medicare Numbe	r, including alpha character(s)							
* 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?	Effective Dat	e of Medicare Part A: _	/ /	Effective date of N	1edicare	Part B:/ /			
Ist 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. / / 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 children)? Who has custody of the children) more than 50% of the time? Documentation of the court order may be requested from your Blue Cross Blue Shield plan. Section Name Relationship Date of Birth Sex Social Security Number (Optional)	Medicare Ent	itlement: Age	Disability*	End Stage Renal Disease (ESRD)*				
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Name Relationship Date of Birth Sex Social Security Number (Optional)				, ,					
	Name		Relationship	Date of Birth	Sex	Social Security Number (Optional)			
			·	-		,			

Date

Policyholder Signature