

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.

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2000 2 11 1 1 1					
BCBS Policyholde	er Name				
BCBS Group Nun	nber		BCBS Member ID Number		
Section A	Other Insura	ince If this do	pes not apply, skip to Section	on B.	
	ny other member o ther Blue Cross Blu			y covered by another r	medical or dental insurance
	o, please complete o other insurance."	Section D, s	ign, date and return t	his questionnaire to us	s, indicating
Yes If Yes	es, please complete	all the fields	below that pertain to t	he member(s) that has	the other coverage.
Mark the	ose that apply:	Other H	Other Dental Insurance		
What typ	pe of policy is this?	Group	Individual Policy	Student Policy	Medicare Supplemental
Other Insurance (Carrier's Name				
City		State		Zip	Phone Number
Dependent(s) liste	ed on the other insuranc	е		1 1	1
Other Insurance F	Policyholder's Name	7		Policyholder's Date of Birth	ID Number
1	1	/			
Effective Date of		If Cancelled, Car	ncellation Date		
Is the policy	nolder: Actively	working for the	Inactive		
ř	Retired,	retirement date:		On COBRA, which b	egan:/ /
Policyholder's Em	nployer				
Address					
Audress		1			
City		State		Zip	Phone Number

Name Relationship Date of Birth Sex Social Security Number (Optional	Section B	Medicare Inform	dicare 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	Yes N	o					
Medicare Number, including alpha characteris) Effective Date of Medicare Part A:										
Effective Date of Medicare Part A:	Name of person(s) with Medicare								
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 Disability: 1st Date of Disability: 2st Date of Disabili	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)? 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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Date

Policyholder Signature