Print Clear form

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Coordination of Benefits Questionnaire

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.

☐ Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

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 Name:

Group Number:	Member ID Number with Three Letter Prefix:

Section A — Other Insurance

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

City	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

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare

Medicare Beneficiary Identification (MBI) Number

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

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 and/or Blue Shield Plan

Section D Names of Dependent(s) on Blue Cross and/or Blue Shield Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder Signature **Date**