Coordination of Benefits Questionnaire

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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.

Please send this completed form to the BCBS Plan that you are a member of.
You can call the customer service phone number on your membership ID card to get the address.

BCBS Policyholder Name

BCBS Group Number | BCBS Member ID Number

Section A | Other Insurance *If this does not apply, 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

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 policyholder: ☐ 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, 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: ☐ 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 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 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 Number (Optional)
		/ /		– –
		/ /		– –
		/ /		– –

Policyholder Signature **Date**