medpartners
Administrative Services
P.O. Box 2602
Fort Wayne, IN 46801
Fax: 260-479-3545

COORDINATION OF BENEFITS QUESTIONNAIRE

This form **MUST** be completed to notify MedPartners Administrative Services of Medicare or other health insurance coverage for Coordination of Benefits (COB). **FAILURE TO COMPLETE THIS FORM WILL RESULT IN DELAYS TO CLAIM PAYMENTS.**

PLEASE CHECK REASON FOR SUBMISSION:

☐ **Annual COB update for calendar year _____** ☐ **New enrollee** ☐ **Add other insurance**
☐ **Termination of other insurance (Please complete Section 1)** ☐ **Add dependent(s)/spouse**

Group Policy # _____ Group or Employer Name _____

Member ID # _____ Member/Employee Name _____

Address _____ Phone # _____

ARE YOU OR ANY OF YOUR COVERED DEPENDENTS ALSO COVERED BY ANOTHER HEALTH PLAN?

☐ **NO** – Please skip the rest of the questions, sign at the bottom, and return.
☐ **YES** – Complete entire form, sign, and return.

SECTION 1 OTHER HEALTH COVERAGE INFORMATION (Excluding Medicare – See Section 3)

Please provide information about policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Social Security #	Employer	Birth date

Insurance company name	Insurance company address	Phone #

Member ID/Policy #	Group #	Effective date	Cancellation date

Type of coverage: ☐ Single ☐ Family

Type of Plan: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug

Who is covered by this other plan? Include yourself if applicable.

	Name (First and Last)	Relationship to You	Effective Date	Cancellation Date
1.				
2.				
3.				
4.				
5.				
6.				

NOTE: For dependent children of divorced, separated, or court-ordered parents, PLEASE complete SECTION 2.

SECTION 2 SPECIAL SITUATIONS FOR DEPENDENT CHILDREN

Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation, etc.

Is there a court order that determines responsibility for health care coverage or custody?

☐ No ☐ Yes – Attach copy of applicable section pertaining to custody and/or health care coverage.

Who does the court order indicate is responsible for insurance/health coverage? _____

Person responsible for child's health care coverage	Social Security #	Relationship	Employer	Birth date

Insurance company name	Insurance company address	Phone #

Member ID/Policy #	Group #	Effective date	Cancellation date

Type of coverage: ☐ Single ☐ Family

Type of Plan: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug

Which children are covered by this insurance?

Child's Name (First and Last)	Who has custody?	Child's Name (First and Last)	Who has custody?
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

SECTION 3 MEDICARE COVERAGE

If you or your spouse has Medicare coverage, please complete the following:

Are you covered by Medicare? ☐ No ☐ Yes ☐ Actively Employed ☐ Retired

Reason for coverage: ☐ Over 65 ☐ Disabled ☐ ESRD (End Stage Renal Disease)

Medicare Claim/ID #: _____

Hospital Part A: Effective Date _____

Hospital Part B: Effective Date _____

Is your spouse covered by Medicare? ☐ No ☐ Yes ☐ Actively Employed ☐ Retired

Reason for coverage: ☐ Over 65 ☐ Disabled ☐ ESRD (End Stage Renal Disease)

Medicare Claim/ID #: _____

Hospital Part A: Effective Date _____

Hospital Part B: Effective Date _____

By signing or typing my name below, I hereby certify that the information I have provided is true and accurate.

MEMBER'S SIGNATURE _____ **DATE** _____

Return completed form to: **MedPartners Administrative Services** **OR** **Fax to: (260) 479-3545**
P.O. Box 2602
Fort Wayne, IN 46801