Patient Name:____________________________ Primary Ins.:_____________________________

Account Number: _________________________ Policyholder Name: ______________________

Date of Service:___________________________ Member ID: ______________________________

Group #:__________________________________

Section A *Primary Insurance*

NAME(S) OF DEPENDENT(S) ON PRIMARY POLICY:

Name	Relationship	Date of Birth	Sex	Social Security # (Optional)
		____/____/____		
		____/____/____		
		____/____/____		

Are you or any other member of your family on this policy covered by another medical or dental insurance policy or Medicare? Check No or Yes below.

- ☐ **No** If ***No***, please sign and date below and return this questionnaire.
- ☐ **Yes** If **Yes**, please sign and date below then complete all the fields below that pertain to the member(s) with the other coverage.

Signature Required: ____ **Date:** ____/____/______

Please provide a copy of all insurance cards. Thank you.

Section B *Other Insurance: If this does not apply, sign above, and return.*

PLEASE CHECK THOSE THAT APPLY:

☐ Health Policy ☐ Dental Policy

TYPE OF POLICY:

☐ Individual ☐ Group ☐ Sport Policy ☐ Student Policy

☐ Medicare Supplement ☐ Champus ☐ Other

Other Insurance Carrier's Name: ________________________________ (If more than one, list on separate page)

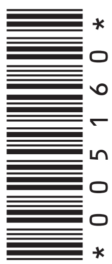
Address: ____

City, State, Zip: ___________________________________ Phone #:______________________________

Other Insurance Policyholder's Name: ____________________________________

Policyholder's Date of Birth: ____/____/______ ID #: _____________

Effective Date of Other Insurance: ____/____/_____ If Cancelled, Cancellation Date: ____/____/_____



Advocate Health Care

COORDINATION OF BENEFITS QUESTIONNAIRE

CREATED BY: Susan Clarke
CREATED DATE: 12/19/2017
REVISED DATE: 12/19/2017

Patient Label

© 2017 Advocate Health Care

Is the policy holder:

☐ Actively working for the group

☐ Inactive

☐ Retired, retirement date: ____/____/_____

☐ On COBRA, which began: ____/____/_____

Policyholders' Employer: ______________________________________

Employer's Address: ____

City, State, & Zip: ____

NAME(S) OF DEPENDENT(S) ON OTHER POLICY:

Name	Relationship	Date of Birth	Sex	Social Security # (Optional)
____________________	________________	____/____/____	____	______________________
____________________	________________	____/____/____	____	______________________
____________________	________________	____/____/____	____	______________________

Section C *Medicare: If this does not apply, sign on the first page, and return.*

MEDICARE INFORMATION:

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:____/____/______

Effective Date of Medicare Part C: ____/____/______ Effective Date of Medicare Part D:____/____/______

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: ____/____/______

Please provide a copy of all insurance cards. Thank you.

© 2017 Advocate Health Care