



BlueCross BlueShield of Illinois  
 BlueCross BlueShield of New Mexico  
 BlueCross BlueShield of Oklahoma  
 BlueCross BlueShield of Texas

## Coordination of Benefits Questionnaire

**BCBS POLICYHOLDER NAME:** \_\_\_\_\_

**BCBS GROUP #:** \_\_\_\_\_

**BCBS MEMBER ID #:** \_\_\_\_\_

Your Blue Cross and Blue Shield contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by Blue Cross and Blue Shield in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply.

**OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)**

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

No If No, please make any revisions necessary to the information in Section A, sign, date and return this questionnaire to us, indicating "No other insurance."

Yes If Yes, please make any revisions necessary to the information in Section A and complete all the fields below that pertain to the member(s) that has the other coverage.

### Section A

**NAME(S) OF DEPENDENT(S) ON BCBS POLICY**

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

**Signature Required:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

### Section B *If this does not apply, skip to Section C.*

Check 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: \_\_\_\_\_ (If more than one, list on separate page)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dependent(s) listed on the other insurance: \_\_\_\_\_ Effective or Cancel Date, if different from policyholder: \_\_\_\_\_

\_\_\_\_\_ /\_\_\_/\_\_\_

\_\_\_\_\_ /\_\_\_/\_\_\_

\_\_\_\_\_ /\_\_\_/\_\_\_

Other Insurance Policyholder's Name: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # \_\_\_\_\_

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: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

**Section C** *If this does not apply, skip to Section D.*

**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:

1<sup>st</sup> Date of Disability: \_\_\_\_/\_\_\_\_/\_\_\_\_

1<sup>st</sup> 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. \_\_\_\_/\_\_\_\_/\_\_\_\_

**In addition, please provide a copy of the Medicare Card**

**Section D**

**COURT ORDER INFORMATION**

Is there a Court Order specifying a person(s) who must maintain health coverage for any of your dependent(s)?

No  Yes

List the name(s) of the dependent(s) to whom the Court Order applies: \_\_\_\_\_

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 Blue Shield plan.*