

Coordination of Benefits Questionnaire



Please Print

Subscriber's Name: _____ Identification Number _____
Last First Middle Initial

Subscriber's Social Security Number: _____ Spouse's Social Security Number: _____

In addition to your Blue Cross and Blue Shield coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare? **Yes** If yes, please complete the entire questionnaire **No** If no, please complete the question below, sign and return to us. **No** If no, please complete the question below, sign and return to us.

If you had other health insurance coverage which cancelled when your **Blue Cross and Blue Shield** coverage became effective, please provide Name of carrier or plan _____ and Cancellation Date _____
Mo. Day Yr.

**Other Health Insurance:
 If Multiple Coverage Exists, Please List On A Separate Sheet Of Paper**

1. Policy Holder's Name: _____ Sex: Male Female
2. Policy Holder's Social Security Number: _____ Date of Birth: _____
Mo. Day Yr.
3. Name of Employer providing coverage: _____
4. Name of Other Insurance Company: _____ Policy Number: _____
5. Address of Other Insurance Company: _____ Phone Number: _____
6. Effective Date of Policy: _____ Cancellation Date of Policy (If Applicable): _____
Mo. Day Yr. Mo. Day Yr.
7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

<i>Name</i>	<i>Relationship to Policy Holder</i>
<i>Name</i>	<i>Relationship to Policy Holder</i>
<i>Name</i>	<i>Relationship to Policy Holder</i>

8. Services Covered: **A. Hospital Services** Yes No **D. Major Medical (Out of pocket expenses not otherwise covered)** Yes No
B. Physician Services Yes No **E. Eye or Vision Care** Yes No
C. Dental Coverage Yes No **F. Catastrophic Benefits Only** Yes No

To be completed for dependents whose natural parents live apart and who provide medical coverage for these dependents. Please indicate relationship to children (natural mother, natural father, step-father). If multiple children, please list on a separate sheet of paper.

Parent With Custody Of Child(ren)	<i>Parent's Name</i>	<i>Relationship to Child</i>	<i>Child's Name</i>	<i>Child's Date of Birth</i>
Parent With Court Assigned Responsibility For Child(ren)s Medical Expenses	<i>Parent's Name</i>	<i>Relationship to Child</i>	<i>Child's Name</i>	<i>Child's Date of Birth</i>

9. Do you or any of your dependents have Medicare? Yes No If Yes, please complete the following:

Participant's Name	Birthdate	Medicare Hic Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Eligible for Medicare as a result of (check one) Age Disability End Stage Renal Disease Participant Actively Employed Yes No

Beginning date of renal treatment: _____
Mo. Day Yr. Spouse Actively Employed Yes No

Subscriber's Signature _____ Date _____ Work Phone Number _____
 Home Phone Number _____

SEND FORM TO:

To facilitate a quicker response to your inquiry, please complete this form and attach all relevant claim information (claim, EOMB, operative notes) and send to the proper address below based on the member's insurance coverage:

■ **MD, NCA, BlueChoice:**

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20077-0856
DSU 517
Fax: 410-308-3260

■ **FEP- Federal Employee Program:**

Mail Administrator
P.O. Box 14113
Lexington, KY 40512-4113

■ **NASCO and Maryland Care Business:**

CareFirst BlueCross BlueShield
PO Box 14114
Lexington, KY 40512-4114

Copies of this form may be obtained by visiting www.carefirst.com › *Members & Visitors* › *Forms*.
