Coordination of Benefits

Blue Cross and Blue Shield of New Mexico

Return to BCBSNM:
P.O. Box 27630
Albuquerque, New Mexico 87125-7630
1-800-432-0750

Date: _____

Policy Holder: _____

Group/Identification Number: _____

Your Blue Cross and Blue Shield plan contains a coordination of benefits provision. **PLEASE RESPOND TO THIS QUESTIONNAIRE WITHIN 15 DAYS.** Processing of claims submitted under your contract depends on your response.

Spouse's First and Last Name: _____

Spouse's Birthdate: _____ **Is your Spouse employed?** ☐ Yes ☐ No

Spouse's Employer: _____ **Employer Address:** _____

Are there any OTHER medical benefits available to you, your spouse, or dependents from OTHER Group Insurance, including OTHER Blue Cross and Blue Shield policies, OTHER Employers, Labor or Professional Organizations, School, Sport or Travel Groups, CHAMPUS, Medicare, etc.?

☐ **No** There is no other insurance **If 'No' was checked, please sign and return.**
☐ **Yes** OTHER insurance exists **If 'Yes' was checked, please complete the following:**

Check all that apply:

☐ **Health** ☐ **Dental** ☐ **Group Coverage (including other Blue Cross and Blue Shield policies)**
☐ **CHAMPUS** ☐ **Individual Policy** ☐ **Student Policy** ☐ **Sport Policy** ☐ **Medicare** ☐ **COBRA**

Note: If OTHER insurance is Medicare only, please complete the Medicare information listed at the bottom of the page.

Name of OTHER Insurance Company: _____

Name of Policy Holder: _____ Birthdate: _____

Insurance Company Address: _____ City, State, & Zip _____

Insurance Company Phone: _____ Policy Number: _____

Policy Effective Date: _____ Cancellation Date: _____

Employer (for OTHER Insurance.): _____ Phone: _____

Is policy holder: ☐ Actively Working ☐ Inactive ☐ Retired as of: _____ ☐ COBRA as of: _____

Indicate whether your family members are covered through this OTHER policy:

	Name	Covered		Birthdate	Social Security #
Spouse:	_____	☐ Yes	☐ No	___/___/___	_____
Dependent:	_____	☐ Yes	☐ No	___/___/___	_____
Dependent:	_____	☐ Yes	☐ No	___/___/___	_____

Medicare/ESRD Coverage Information

Name: _____ Health Insurance Claim Number (HICN) located on the Medicare Card: _____

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___

Name: _____ Health Insurance Claim Number (HICN) located on the Medicare Card: _____

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___

Signature _____ **Date:** _____

If we do not receive the requested information within the 45-day period following the date of this letter, your claim will be denied on the 45th day.