

In order to process claims, this form <u>must</u> be completed and returned to Blue Cross of Idaho. You may call 800-289-8614 for coordination of benefits.

## **COORDINATION OF BENEFITS**

Dear Blue Cross of Idaho Enrollee:

Before we can process your claims, we must know if you, your spouse or dependents have other health insurance coverage. We will confirm this information with you annually.

The reason for this request is that your Blue Cross of Idaho Agreement has a coordination of benefits provision. If you or your family members have coverage under more than one Blue Cross/Blue Shield Plan or through another carrier, the benefits are coordinated so the carriers do not make duplicate payments for service.

Name and Birth Date of Policy Holder on Other Insurance					tionship to Cross of Idaho	Enrollee	Name of Other Group Insurance Plan			Other Insurance Phone # (Area) Telephone Number	
Address You Send You	ır Claims to						City	St	ate	Zip	
This Coverage is for:	☐ Medical	Includes:	☐ Spouse	☐ Self	☐ Children	Identificat	tion Number of Other Pl	an		☐ Group	☐ Active
	☐ Vision	Includes:	☐ Spouse	☐ Self					☐ Individual		
	Dental	Includes:	☐ Spouse	☐ Self	Children	Effective	Date of Other Coverage	ı		Termination Date	е
	□ Rx	Includes:	☐ Spouse	☐ Self	☐ Children						
PART 2 - OTHE	R REQU	IRED IN	FORMATIC	N							
s your spouse, or	are any of	your dep	endents, cu	rrently e	mployed?	☐ Yes, co	emplete this section	n 🗖 No, go t	o Part 3		
Spouse's Birth Da	te:										
f so, please list fa	mily memb	er name,	relationship	and pla	ce of employ	yment.					
						_					
Name				Rela	ationship		Employer			City, State	
Name				Relationship		-	Employer			City, State	
PART 3 – MEDI	CARE										
Do you or any of y		dents hav	e Medicare	coverag	e? □ Ye:	s comple	te this section	No go to Par	rt 4		
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	and anyona	d undor:				N	ame			Medicare Numi	ber
o) Is person nam			icos)		□ Voc			octivo Dato:			
b) Is person nam	Part A (Hos	pital Serv	,		☐ Yes	□ No	Effe	ective Date:			
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Is person nam     Medicare F     Medicare F     Medicare I	Part A (Hos Part B (Phy Disability End Stage	spital Serv vsician Se Renal Dis	rvices) ease	ı	☐ Yes	□ No □ No □ No	Effe Effe	ective Date:			
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