BlueCross BlueShield of Illinois

Coordination of Benefits Questionnaire

REMIT TO:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

BCBS POLICYHOLDER NAME:	
BCBS GROUP #:	
BCBS MEMBER ID #:	

Your Blue Cross and Blue Shield of Illinois (BCBSIL) contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by BCBSIL 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.

OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)
Are you or any other member of this Blue Cross and Blue Shield of Illinois 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 BCBSIL POLICY

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

_____

_____

_____

Signature Required _____ Date _____

SECTION B

IF THIS DOES 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 Supplement

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 Canceled, 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 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:

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 date of the transplant. _____

IN ADDITION, PLEASE PROVIDE A COPY OF THE MEDICARE CARD

SECTION D

COURT ORDERED INFORMATION

Is there a Court Order specifying a person(s) who must maintain health coverage for any of your dependent(s)? ☐ Yes ☐ No

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.