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 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 _____

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

8. Services Covered:
A. Hospital Services ☐ Yes ☐ No
B. Physician Services ☐ Yes ☐ No
C. Dental Coverage ☐ Yes ☐ No
D. Major Medical (Out of pocket expenses not otherwise covered) ☐ Yes ☐ No
E. Eye or Vision Care ☐ 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's Name	*Relationship to Child*	*Child's Name*	*Child's Date of Birth*
Parent With Custody Of Child(ren)				
Parent With Court Assigned Responsibility For Child(ren)s Medical Expenses				

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.*