

Coordination of Benefits Questionnaire

Your membership agreement requires us to coordinate benefits for all family members to determine primary and secondary responsibility for claims payments. Please be advised that failure to return the completed and signed survey may delay the processing of your claims.

WE CANNOT PROCESS THIS FORM WITHOUT THE MEMBER'S SIGNATURE AT THE BOTTOM.

Is anyone covered by your Blue Cross and Blue Shield of Oklahoma benefit plan also covered under another health care policy or Medicare? CHECK ONE:

NO (sign and return)

YES (provide complete information below)

SECTION 1- OTHER INSURANCE INFORMATION						
Name of policyholder who has the OTHER group health insurance policy: (For Medicare only, skip to Section 3.)						
NAME (LAST, FIRST)	BIRTHDATE (MO., DAY, YEAR)	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER			
NAME AND ADDRESS OF OTHER POLICYHOLDER'S EMPLOYER		NAME AND ADDRESS OF OTHER INSURANCE CARRIER				
PHONE NUMBER ()		TYPE OF OTHER COVERAGE	PHONE NUMBER ()			
		MEDICAL <input type="checkbox"/>	DENTAL <input type="checkbox"/>	DRUGS <input type="checkbox"/>		
		POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	CANCELLATION DATE	
LIST THE NAMES OF YOUR FAMILY MEMBERS WHO ARE COVERED BY THE POLICY INDICATED IN SECTION 1 ABOVE INCLUDING YOURSELF.						
NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)			
NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)			
NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YEAR)			
SECTION 2- DIVORCE/SEPARATION INFORMATION						
If a dependent child not mentioned above has coverage resulting from a divorce or separation, complete this section.						
NAME (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YR.)	PARENT WITH PRIMARY CUSTODY (CHECK ONE)	IS THERE A COURT ORDER FOR PAYMENT OF CHILD'S HEALTH CARE EXPENSE?	IF YES, NAME OF PARENT WITH PRIMARY RESPONSIBILITY	NAME, ADDRESS AND PHONE NO. OF INSURANCE CARRIER	
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)			
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)			
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)			
SECTION 3- MEDICARE INFORMATION						
List any family member who is eligible for Medicare benefits including yourself.						
NAME OF FAMILY MEMBER (LAST, FIRST)	DATE OF BIRTH (MO., DAY, YR.)	HEALTH INSURANCE CLAIM NUMBER	PART A EFFECTIVE DATE (M/D/Y)	PART B EFFECTIVE DATE (M/D/Y)	REASON FOR MEDICARE ELIGIBILITY	ACTIVELY EMPLOYED?
					<input type="checkbox"/> AGE 65 OR OLDER <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> AGE 65 OR OLDER <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)	<input type="checkbox"/> YES <input type="checkbox"/> NO
YOUR SIGNATURE				DATE		

IF YOU HAVE ANY QUESTIONS ABOUT HOW TO COMPLETE THIS FORM, CALL 1-888-549-4615