

COORDINATION OF BENEFITS QUESTIONNAIRE



Please complete the following and fax to 410-308-3260 or mail to:
 OPL, Mail Stop York 10, 10455 Mill Run Circle, Owings Mills, MD 21117

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 this questionnaire NO If no, please complete the questionnaire below, sign and send 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 Other Insurance Company: _____ Policy Number: _____
4. Address of Other Insurance Company: _____
5. Effective Date of Policy: / / Cancellation Date of Policy (If Applicable): / /
Mo. Day Yr. Mo. Day Yr.
6. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

_____	_____
<i>Name</i>	<i>Relationship to Policy Holder</i>
_____	_____
<i>Name</i>	<i>Relationship to Policy Holder</i>
_____	_____
<i>Name</i>	<i>Relationship to Policy Holder</i>

7. Services Covered: **A. Hospital Services** Yes No **D. Major Medical** (Out of pocket expenses not otherwise covered) Yes No
B. Physician Services Yes No **E. Eye or Vision Care** Yes No
C. Dental Coverage 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 WITH CUSTODY OF CHILD(REN) PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)S MEDICAL EXPENSES	_____	_____	_____	_____
	<i>Parent's Name</i>	<i>Relationship to Child</i>	<i>Child's Name</i>	<i>Child's Date of Birth</i>
	_____	_____	_____	_____
	<i>Parent's Name</i>	<i>Relationship to Child</i>	<i>Child's Name</i>	<i>Child's Date of Birth</i>

8. 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) <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE			Participant Actively Employed	Spouse Actively Employed
Beginning date of renal treatment: <u> </u> / <u> </u> / <u> </u> <small>Mo. Day Yr.</small>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Subscriber's Signature _____ Date _____ Work Phone Number _____
 Home Phone Number _____