ORLANDO HEALTH
1414 Kuhl Ave. • Orlando, FL 32806-2093

Coordination of Benefits Questionnaire

ED#:

DOB:

ATD:

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):
Policyholder Name:	
Patient Name: (last, first, middle initial)	
Group Number:	Member ID Number with Three Letter Prefix:

Section A Other Insurance *if this does not apply, check NO and skip to Section B*

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or Blue Shield policy or Medicare?

☐ No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark 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

Address

Address | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth | ID Number

Effective Date of Other Insurance | If Cancelled, Cancellation Date

Is the policy holder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date___________ ☐ On COBRA, which began:__________________

Policyholder's Employer:____

Address

City State Zip | Phone Number

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Section B Medicare Information *if this does not apply, check NO and skip to Section C*

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:_______________________

Medicare Entitlement: ☐ Yes ☐ Disability ☐ Yes ☐ 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 the date of the transplant:____________________

Section C Court Order Information *if this does not apply, check NO and skip to Section D*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ Yes ☐ No

List the name(s) of the dependent(s) that this applies to:____

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/or Blue Shield Plan

Section D Names of Dependent(s) on Blue Cross and/or Blue Shield Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder / Patient Signature:____Date:________________