



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Visit our Web site at: www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

Blank lines for ID Number and Date

1. Do you or any dependents have any other group health, dental or Medicare coverage? [ ] No [ ] Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (1-800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. Please list the family members covered by the other policy and the type of coverage you have. [ ] Medical [ ] Hospital [ ] Drug [ ] Dental [ ] Medicare

For additional family members, attach a separate sheet with the information.

\* If you checked Medicare, answer question #7 on page 2.

3. Name of Other Policyholder: \_\_\_\_\_

Other Policyholder's Date of Birth: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

4. Employer's Name, If Coverage is Provided Through an Employer: \_\_\_\_\_

5. Name of Other Insurance Company and Effective Date of Policy: \_\_\_\_\_ Effective Date: \_\_\_\_\_

If policy is now terminated, please give termination date: \_\_\_\_\_ ID#: \_\_\_\_\_

6. If there is a divorce or separation, please list who is responsible for the health care expenses: \_\_\_\_\_

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? \_\_\_\_\_

\*\*\*\*\* SECTION PERTAINS TO MEDICARE COVERAGE ONLY \*\*\*\*\*

7. Are you actively working?  Yes  No Start Date: \_\_\_\_\_ Last Day of Active Employment: \_\_\_\_\_

8. Are you or any family members covered by Medicare?  No  Yes  
If No, please sign and date below. If Yes, please complete the information below.

• Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_  
Part B Effective Date: \_\_\_\_\_  
Reason for Medicare (check one):  Age  Disability  ESRD Date of First Dialysis: \_\_\_\_\_

• Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_  
Part B Effective Date: \_\_\_\_\_  
Reason for Medicare (check one):  Age  Disability  ESRD Date of First Dialysis: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax this form to the correct plan:

- State Health Plan ("ZCS" Alpha Prefix) State Health Plan: AX-B10  
ATTN: COB  
P.O. Box 100605, Columbia, SC 29260-0605  
Fax: (803) 699-7675
- Federal Employee Plan/FEP ("R" Alpha Prefix) Federal Employee Customer Service  
P.O. Box 100603  
Columbia, SC 29260-9982  
Fax: (803) 736-8341
- Small Group and Individual ("ZCY" Alpha Prefix) Group and Individual: AX-F25  
ATTN: COB  
P.O. Box 100246, Columbia, SC 29202-3246  
Fax: (803) 264-0172
- Preferred Blue® and All Other BlueCross Plans (Include name of health plan.) BlueCross BlueShield of South Carolina  
P.O. Box 100300  
Columbia, SC 29202  
Check your member ID card for Service Center location:  
Piedmont (Greenville) Service Center: Fax: (803) 264-9128  
Columbia Service Center: Fax: (803) 264-6572