

# OTHER HEALTH COVERAGE QUESTIONNAIRE



Your contract contains a Coordination of Benefits (COB) provision to ensure correct benefits are provided on claims for members covered by more than one health insurance plan. We need information about possible other insurance coverage, including Medicare, before we can process your claims. Please complete this form and return it to the address listed on the bottom of this form. If you or a family member has Medicare or other coverage that has already provided benefits for these services, please attach the Explanation of Benefits notice to this form. If you have any questions or need help to fill out this form, please call 1-800-868-2528. Thank you for your cooperation.

I.D. Card #: _____		Name on ID Card: _____	
		First Name	Last Name
Your Spouse's Name: _____		Spouse's Social Security Number: _____	Spouse's Date of Birth: _____
Is your Spouse employed? Yes _____ No _____	If your spouse is employed, please list the employer's name and telephone number: _____		
Are you actively at work? Yes _____ No _____	If you are actively at work, your work schedule is: FULL-TIME _____ PART-TIME _____	Date that you began work with current employer: _____	
Are you retired? Yes _____ No _____ If "yes," your retirement date: _____			
Do you have group health insurance under continuation of coverage (COBRA)? If "Yes," please give the date that continuation under COBRA began: Yes _____ No _____			
Do you, your spouse, or dependent child(ren) have Medicare coverage? Yes _____ No _____			
If "Yes," please list the names, dates of birth, Medicare ID Numbers, and effective dates of hospital and medical coverage for all family members who have Medicare because:			
They are age 65 or older:	They are disabled:	They have permanent kidney failure:	
Are any family members disabled but not yet covered by Medicare? Yes _____ No _____ If "Yes," please list their names, dates of birth, and dates that disability began: _____			
Do any family members have permanent kidney failure, but are not yet covered by Medicare? Yes _____ No _____ If "Yes," please list their names, dates of birth, and dates that kidney dialysis began: _____			
Are you, your spouse, or dependent child(ren) covered by a group health plan other than this one? Yes _____ No _____ If "Yes," please furnish the following information:			
Name of Policyholder with other coverage: _____	Policyholder's relationship to you: _____	Name of other insurance company: _____	
Check each type of service covered by the other plan: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> PHYSICIAN/MEDICAL <input type="checkbox"/> PRESCRIPTION DRUGS <input type="checkbox"/> DENTAL CARE			
Names of all family members covered by the other plan: _____			
If divorced or separated, is there a court decree establishing financial responsibility for the health care expenses of the child(ren)? Yes _____ No _____ If "Yes," name of responsible person: _____ If "No," who has custody of the child(ren)? _____			

CERTIFICATION: I certify that the information I have provided is complete, true, and correctly recorded to the best of my knowledge.

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

PLEASE RETURN THIS FORM TO BLUECHOICE HEALTHPLAN, MAIL CODE AX-420, P.O. BOX 6170, COLUMBIA, SC 29260-6170 OR FAX TO 803-714-6443.