



CDPHP® Medicare Choices Coordination of Benefits Inquiry Form

Please take a few minutes to fill out this form and return it to CDPHP® in the enclosed, postage-paid envelope. The Federal government requires a response to this survey so your prompt attention is greatly appreciated. Please note that references to “CDPHP” in this document refer to both Capital District Physicians’ Health Plan, Inc. and CDPHP Universal Benefits®, Inc.

Your Name: _____ Your CDPHP Member ID #: _____

Your employment status: (check one) Active Retired (Date: _____)

Please check which of the following apply and follow the instructions in italics:

- 1. I have NO other health or prescription drug coverage. *If checked, please complete Section B only.*
- 2. I HAVE other health and/or prescription drug coverage. *If checked, please complete Sections A & B.*

Section A—If you checked # 2 above, please use your insurance card(s) to provide the following information:

Name of policy holder with other health or prescription drug coverage: _____

Family member(s) insured: _____

Other insurance company name: _____

Other insurance company address: _____ Phone (____) _____

Other plan type: (check one) Individual Family Husband/Wife Parent/Child

Other benefit coverage: (check what is applicable) Medical Hospital Dental Prescription Drug*

*If Prescription plan, complete: RxBIN# _____ RxPCN# _____ RxGroup# _____

ID # for other policy: _____ Group # for other policy: _____

Employment status of other insurance policy holder: (check one) Active Retired (Date: _____)

Have you been diagnosed with **End Stage Renal Disease (ESRD)**? Yes No

If yes, are you on dialysis? (check one) Yes No If Yes, date dialysis began: _____

Where is dialysis administered? Home Hospital

Did you receive a transplant? (check one) Yes No If Yes, date of transplant: _____

Section B—All respondents: Please provide signature, date, and patient identification number below:

The Coordination of Benefits provision is part of your plan. You agree to abide by the provision through enrollment in your plan. Any person who knowingly and with intent to defraud any insurance company by filing a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime.

Signature _____ CDPHP Member ID# _____ Date _____