Medicare Advantage Coordination of Benefits Verification Questionnaire

Member Name: ______________________ Date: ____________

Street Address: ______________________

City, State, ZIP Code: ______________________

Telephone: ______________________ Member ID# *(on ID card)*: ____________

In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, please complete the following Coordination of Benefits questionnaire and sign the reverse. This questionnaire helps us validate your primary health insurance. Even if you do not have other health insurance in addition to your CDPHP® Medicare Advantage plan, completing this form will prevent delays when we process your claims.

How to submit this form: Visit member.cdphp.com and log in to your CDPHP member account (or register for a new one). Then select **Contact Us**, and attach the form to the **Secure Email** option. You can also mail the form to:

CDPHP
500 Patroon Creek Blvd.
Albany, NY 12206-1057

1. In addition to your CDPHP Medicare Advantage health plan, will you or your spouse *(if applicable)*, have any other health insurance coverage through another CDPHP plan or another health insurance carrier?

   ◯ NO. *Please proceed to Question 2, then sign the form (on the reverse) and return it to CDPHP.*

   ◯ YES. *Please skip to Question 3 (on the reverse), then sign the form and return it to CDPHP.*

2. If you answered "NO" to Question #1 and you will not have coverage through another CDPHP plan *(other than your Medicare Advantage Plan)* or through another health insurance carrier, please provide the following information:

   Date Coverage Ended: ______________________

   Name of Primary Insurance Holder: ______________________

   Name of Employer: ______________________

   Size of Employer: ◯ 1–19 employees ◯ 20–99 employees ◯ 100 or more employees

   Name of Insurance Company: ______________________

   Insurance Company Address: ______________________

   Insurance Company City, State, Zip: ______________________

   Insurance Company Phone Number: ______________________

   Type of Coverage *(check and provide info for all that apply)*:

   ◯ Medical: Group Number ____________ ID Number ____________

   ◯ Prescription: Group Number ____________ ID Number ____________

   ◯ Dental: Group Number ____________ ID Number ____________

3. If you answered "YES" to Question #1 and you will have coverage through another CDPHP plan (other than your Medicare Advantage Plan) or through another health insurance carrier, please provide the following information:

Name of Primary Insurance Holder: ______________________________

Current working status of Primary Insurance Holder: ◯ Actively working

◯ Retired *(If retired, please provide the date that you retired)*: ______________

Name of Employer: ______________________________

Size of Employer: ◯ 1–19 employees ◯ 20–99 employees ◯ 100 or more employees

Name of Insurance Company: ______________________________

Insurance Company Street Address: ______________________________

Insurance Company City, State, Zip: ______________________________

Insurance Company Phone Number: ______________________________

Type of Coverage *(check and provide info for all that apply)*:

◯ Medical: Group Number ____________ ID Number ____________

◯ Prescription: Group Number ____________ ID Number ____________

◯ Dental: Group Number ____________ ID Number ____________

Please contact CDPHP if any of your answers change in the future.

Please read the following important information, and sign and date 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. Please note that references to "CDPHP" in this document refer to both Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits,® Inc. Both companies are health plans with a Medicare contract. Enrollment in CDPHP Medicare Advantage depends upon contract renewal.

Signature *(required)*: ______________________________ Date: ______________

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