Instructions for Completing A Coordination of Benefits Questionnaire

The accompanying coordination of benefits (COB) questionnaire contains questions about other forms of insurance you may have. Having up-to-date COB information enables your employer's benefit plan to save money by avoiding duplicate payments or overpayment.

Even if you do not have another form of insurance, please complete and sign the form. It will help prevent future delays in paying medical claims on your behalf.

Please complete and sign the *COB Questionnaire* and mail it to:

Capital District Physicians' Health Plan, Inc.
COB Unit, Claims Operations
6 Wellness Way
Latham, NY 12110

Alternatively, you may fax the form to the COB department at (518) 641-3503.

Please read the following directions and complete only the sections of the form that apply to you and any enrolled dependents.

- If you and any enrolled dependents have NO other health insurance coverage, please check #1 on the *COB Questionnaire* and complete Section C (signature).

- If you or any enrolled dependents have other health insurance coverage, please check #2 on the *COB Questionnaire*, and complete Sections A and C (signature).

- If you or any enrolled dependents have **Medicare** coverage, please check #3 on the *COB Questionnaire*, and complete Sections B and C (signature).

If you have any questions, please contact a CDPHP member service representative at the phone number on your ID card.

Plan Subscriber Name:_____

Plan Subscriber Identification Number:_____

1. _____ I (and/or my dependents) have NO other health coverage. (Skip to Section C.)
2. _____ I (and/or my dependents) have other health insurance coverage. (Complete Sections A and C.)
3. _____ I (and/or my dependents) have **Medicare** coverage. (Complete Sections B and C.)

Section A – If you checked #2 above please complete the following:

Name of subscriber of other insurance: _____

Do you or family members have any other prescription drug plans? **YES** _____ **NO** _____

Family member(s) insured: _____

Other Insurance Company name: _____

Other Insurance Company address: _____

Phone #:_____

ID # (other policy) _____ Group # (other policy) _____

Other Plan type: (circle) **Individual** **Family** **Husband/Wife** **Parent/Child**

Other Benefit Coverage: (circle if applicable) **Medical** **Hospital** **Dental**

Employment status of CDPHP subscriber: (circle) **Active** **Retired** Retirement date:_____

Employment status of other insurance subscriber: (circle) **Active** **Retired** Retirement date:_____

Section B – If you checked #3 above please complete the following:

Family member(s) insured: _____Medicare # ___ ___ ___- ___ ___ - ___ ___ ___ ___-___

Effective Date **Part A**: _____/_____/_____ Effective Date **Part B**: _____/_____/_____

Employment status of Medicare Insured: (circle) **Active** **Retired** Retirement date:_____

Employment status of CDPHP subscriber: (circle) **Active** **Retired** Retirement date:_____

Medicare insured is eligible for Medicare benefits because of: (circle) **Age (65)** **Disability**

End Stage Renal Disease (ESRD)

If you have indicated ESRD, is individual on dialysis? (circle one) **YES** Date dialysis began: _____ **NO**

If you indicated "yes" please circle where dialysis is administered: **Home** **Hospital**

Did individual receive a transplant? (circle one) **YES** Date of transplant:_____ **NO**

Section C – All respondents: Please provide signature, date, and member identification number below:

The Coordination of Benefits ("COB") provision is part of your group health insurance plan. You agree to abide by the COB provision through enrollment in your group health insurance 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 **Member ID** **Date**