Coordination of Benefits Questionnaire

Please Print

Subscriber's Name: _____ Identification Number _____
Last First Middle Initial

Subscriber's Social Security Number: _____ Spouse's Social Security Number: _____

In addition to your Blue Cross and Blue Shield coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare? ☐ **Yes** If yes, please complete the entire questionnaire below, sign and return to us. ☐ **No** If no, please complete the question below, sign and return to us.

If you had other health insurance coverage which cancelled when your **Blue Cross and Blue Shield** coverage became effective, please provide
Name of carrier or plan _____ and Cancellation Date ____ / ____ / ____
Mo. Day Yr.

Other Health Insurance:
If Multiple Coverage Exists, Please List On A Separate Sheet Of Paper

1. Policy Holder's Name: _____ Sex: ☐ Male ☐ Female
2. Policy Holder's Social Security Number: _____ Date of Birth: ____ / ____ / ____ (Mo. Day Yr.)
3. Name of Employer providing coverage: _____
4. Name of Other Insurance Company: _____ Policy Number: _____
5. Address of Other Insurance Company: _____ Phone Number: _____
6. Effective Date of Policy: ____ / ____ / ____ (Mo. Day Yr.) Cancellation Date of Policy (If Applicable): ____ / ____ / ____ (Mo. Day Yr.)
7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

_____ Name	_____ Relationship to Policy Holder
_____ Name	_____ Relationship to Policy Holder
_____ Name	_____ Relationship to Policy Holder

8. Services Covered:
   - **A.** Hospital Services ☐ Yes ☐ No
   - **B.** Physician Services ☐ Yes ☐ No
   - **C.** Dental Coverage ☐ Yes ☐ No
   - **D.** Major Medical (Out of pocket expenses not otherwise covered) ☐ Yes ☐ No
   - **E.** Eye or Vision Care ☐ Yes ☐ No
   - **F.** Catastrophic Benefits Only ☐ Yes ☐ No

To be completed for dependents whose natural parents live apart and who provide medical coverage for these dependents. Please indicate relationship to children (natural mother, natural father, step-father). If multiple children, please list on a separate sheet of paper.

	Parent's Name	Relationship to Child	Child's Name	Child's Date of Birth
Parent With Custody Of Child(ren)				
Parent With Court Assigned Responsibility For Child(ren)s Medical Expenses				

9. Do you or any of your dependents have Medicare? Yes ☐ No ☐ If Yes, please complete the following:

Participant's Name	Birthdate	Medicare Hic Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Eligible for Medicare as a result of (check one) ☐ Age ☐ Disability ☐ End Stage Renal Disease

Beginning date of renal treatment: ____ / ____ / ____ (Mo. Day Yr.)

Participant Actively Employed ☐ Yes ☐ No

Spouse Actively Employed ☐ Yes ☐ No

Subscriber's Signature _____ Date _____ Work Phone Number _____

Home Phone Number _____

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

UHS Universal Health

80-030

(PATIENT IDENTIFICATION)

Blue Cross
and
Blue Shield
of the National Capital Area

Government-wide Service Benefit Plan
550 12th Street, S.W.
Washington, DC 20065

NOTE: WE NEED YOUR HELP TO PROCESS YOUR CLAIMS CORRECTLY. PLEASE COMPLETE THE QUESTIONNAIRE ON THE BACK OF THIS LETTER AND RETURN IT WITHIN 10 DAYS.

Dear Federal Subscriber:

When a patient is covered under two health benefit plans, the plans follow coordination of benefits guidelines to ensure that the combined payment made by the two carriers does not exceed the actual expense incurred by the patient. By following these guidelines, health insurance carriers are able to help contain the cost of health care coverage.

Our contractual agreement with the Office of Personnel Management requires that we obtain information concerning other health insurance coverage held by our Federal subscribers and their family members. We are currently conducting a survey to update our records and, to do so, we need your assistance. Please complete the Coordination of Benefits Questionnaire on the back of this letter and return it to us immediately in the postage paid envelope provided. It is important that you return this questionnaire, even if your family members have no other health insurance.

PLEASE ASSIST US AND HELP AVOID CLAIMS PROCESSING DELAYS BY COMPLETING THIS QUESTIONNAIRE TODAY AND RETURNING IT TO US WITHIN 10 DAYS.

We appreciate your cooperation. Please contact us if you have any questions.

Sincerely,

Customer Service Department
(202) 484-1650

FEDERAL BLUE CROSS AND BLUE SHIELD SUBSCRIBER

Blue Cross and Blue Shield of the National Capital Area

COORDINATION OF BENEFITS QUESTIONNAIRE

PLEASE PRINT

IDENTIFICATION NUMBER: R ☐☐☐☐☐☐☐☐☐

Employee Name: _____ Sex: ☐ Male ☐ Female Date of Birth ____/____/____
Last First Middle Initial *Mo. Day Yr.*

Subscriber's Social Security Number: _____ Spouse's Social Security Number _____

Address: _____

_____

A. OTHER COVERAGE INFORMATION

1. Do you have other health insurance? ☐ Yes ☐ No (If yes, indicate your status) ☐ Retired ☐ Annuitant ☐ Actively Employed
2. Do other family members have other health insurance? ☐ Yes ☐ No
   If yes, indicate their status: ☐ Retired ☐ Annuitant ☐ Actively Employed
3. Is your spouse employed? ☐ Yes ☐ No (If yes, indicate name of employer) _____

B. If you answered "Yes" to questions 1 and/or 2, please provide the following information about the other health insurance:

1. Policy Holder Name: _____ Sex: ☐ Male ☐ Female Date of Birth ____/____/____
   Last First Middle Initial *Mo. Day Yr.*
2. Insurance Company Name: _____
   Address of other Insurance Company: _____
3. Policy or Identification Number: _____
4. Effective Date of Policy Mo_____ Day_____ Yr._____ Cancellation Date (if applicable) Mo_____ Day_____ Yr._____
5. Policy Covers: Policy Holder Only _____ Two Persons_____ Family_____

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

6. Services Covered: A. Medical Coverage ☐ Yes ☐ No
   B. Dental Coverage ☐ Yes ☐ No
   C. Mental Condition/Substance Abuse Coverage ☐ Yes ☐ No
   D. Other-Please Describe: _____ ☐ Yes ☐ No
7. Is this for Catastrophic Benefits Only? ☐ Yes ☐ No
8. Is coverage through an Employer or Other Group? ☐ Yes ☐ No
   If yes, Name of Employer or Other Group: _____

To be completed if the natural parents live apart and provide medical coverage for their children. Please indicate relationship to children (natural mother, natural father, step parent):

PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES
_____ _____ _____ _____
Parent's Name *Date of Birth* *Relationship to Child* *Child's Name*

PARENT WITH CUSTODY OF CHILD(REN)
_____ _____ _____ _____
Parent's Name *Date of Birth* *Relationship to Child* *Child's Name*

Do you or any of your dependents have MEDICARE? ☐ Yes ☐ No If YES, please complete the following:

Name _____ MEDICARE HIC Number: _____

Effective Date of Part A (Hospital Coverage) _____ Effective Date of Part B (Medical Coverage) _____

Patient is eligible for MEDICARE as a result of (check one) ☐ Age ☐ Disability ☐ End Stage of Renal Disease

Beginning date of renal treatment: Mo_____ Day_____ Yr._____ If patient is over 65, is he or she an active federal employee? ☐ Yes ☐ No

_____ _____ _____ _____
Signature *Date* *Home Phone Number* *Work Phone Number*

80-030 (04/04)