Illinois
New Mexico
Oklahoma
Texas

Coordination of Benefits Questionnaire

BCBS Policyholder Name: ______________________________

BCBS Group #: ______________________________

BCBS Member ID#: ______________________________

Your Blue Cross and Blue Shield contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by Blue Cross and Blue Shield in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply.

OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)

Are you or any other member of this Blue Cross and Blue Shield policy covered by another medical or dental insurance policy or any other Blue Cross and Blue Shield policy?

☐ **No** If *No*, please make any revisions necessary to the information in Section A, sign, date and return this questionnaire to us, indicating “No other insurance.”

☐ **Yes** If *Yes*, please make any revisions necessary to the information in Section A and complete all the fields below that pertain to the member(s) that has the other coverage.

SECTION A

NAME(S) OF DEPENDENT(S) ON BCBS POLICY

Name	Relationship	Date of Birth	Sex	Social Security # (Optional)
____________	____________	___ / ___ / ___	_____	_______ – ______ – ________
____________	____________	___ / ___ / ___	_____	_______ – ______ – ________
____________	____________	___ / ___ / ___	_____	_______ – ______ – ________

Signature Required:______________________________ Date: ____ / _____ / _____

SECTION B

If this does not apply, skip to Section C.

Check those that apply:	☐ Other Health Insurance ☐ Other Dental Insurance
What type of policy is this?	☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental
Other Insurance Carrier’s Name:	*(If more than one, list on separate page)*
Address:	
City:	State: Zip Code:
Phone Number:	

Dependent(s) listed on the other insurance:	Effective or Cancel Date, if different from policyholder:
______________________________	____ / ____ / ____
______________________________	____ / ____ / ____
______________________________	____ / ____ / ____

Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of New Mexico,
Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas,
Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Other Insurance Policyholder's Name:			
Policyholder's Date of Birth:	___ / ___ / ___	Identification #:	
Effective Date of Other Insurance:	___ / ___ / ___	If Cancelled, Cancellation Date:	___ / ___ / ___
Is the policyholder:	☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: __ / __ / __ ☐ On COBRA, which began: __ / __ / __		
Policyholder's Employer:			
Employer's Address:			
City:		State:	Zip Code:

SECTION C

If this does not apply, skip to Section D.

MEDICARE INFORMATION

Do the policyholder and/or dependent(s) have Medicare?	☐ Yes ☐ No		
Name of person(s) with Medicare:			
Medicare Number, including alpha character(s):			
Effective Date of Medicare Part A:	___ / ___ / ___	Effective Date of Medicare Part B:	___ / ___ / ___
Effective Date of Medicare Part C:	___ / ___ / ___	Effective Date of Medicare Part D:	___ / ___ / ___
Medicare Entitlement:	☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*		

*If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: ___ / ___ / ___

1st Date of Dialysis for ESRD: ___ / ___ / ___

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If *yes*, please provide the date of the transplant. ___ / ___ / ___

In addition, please provide a copy of the Medicare Card

SECTION D

COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) who must maintain health coverage for any of your dependent(s)?	☐ No ☐ Yes
List the name(s) of the dependent(s) to whom the Court Order applies:	
If yes, who is the person(s) listed to maintain health coverage?	
What is the relation to the child(ren)?	
Who has custody of the child(ren) more than 50% of the time?	

Documentation of the court order may be requested from your Blue Cross and Blue Shield plan.