In order to process claims, this form must be completed and returned to Blue Cross of Idaho. You may call 800-289-8614 for coordination of benefits.

COORDINATION OF BENEFITS

Dear Blue Cross of Idaho Enrollee:

Before we can process your claims, we must know if you, your spouse or dependents have other health insurance coverage. We will confirm this information with you annually.

The reason for this request is that your Blue Cross of Idaho Agreement has a coordination of benefits provision. If you or your family members have coverage under more than one Blue Cross/Blue Shield Plan or through another carrier, the benefits are coordinated so the carriers do not make duplicate payments for service.

Do you or any family members listed on your coverage currently have or in the past year had other group health or individual policy coverage, including other Blue Cross of Idaho or Medicare coverage? ❒ Yes, complete Part 1 below ❒ No, go to Part 5, Sign, date and return.

PART 1 – GENERAL INFORMATION

Name and Birth Date of Policy Holder on Other Insurance	Relationship to Blue Cross of Idaho Enrollee	Name of Other Group Insurance Plan	Other Insurance Phone # (Area) Telephone Number ( )
Address You Send Your Claims to		City / State / Zip	

This Coverage is for:					
	❒ Medical	Includes:	❒ Spouse	❒ Self	❒ Children
	❒ Vision	Includes:	❒ Spouse	❒ Self	❒ Children
	❒ Dental	Includes:	❒ Spouse	❒ Self	❒ Children
	❒ Rx	Includes:	❒ Spouse	❒ Self	❒ Children

Identification Number of Other Plan	❒ Group ❒ Individual ❒ Active ❒ Retiree
Effective Date of Other Coverage	Termination Date

PART 2 – OTHER REQUIRED INFORMATION

Is your spouse, or are any of your dependents, currently employed? ❒ Yes, complete this section ❒ No, go to Part 3

Spouse's Birth Date:__________

If so, please list family member name, relationship and place of employment.

Name	*Relationship*	*Employer*	*City, State*

PART 3 – MEDICARE

Do you or any of your dependents have Medicare coverage? ❒ Yes, complete this section ❒ No, go to Part 4

a) Name of person covered and Medicare Number: ______________________ *Name* ______________ *Medicare Number*

b) Is person named covered under:

1. Medicare Part A (Hospital Services) ❒ Yes ❒ No Effective Date: ____________
2. Medicare Part B (Physician Services) ❒ Yes ❒ No Effective Date: ____________
3. Medicare Disability ❒ Yes ❒ No Effective Date: ____________
4. Medicare/End Stage Renal Disease ❒ Yes ❒ No Effective Date: ____________

PART 4 – CHILD CUSTODY INFORMATION

Are the parents of any of your children divorced or legally separated? ❒ Yes, complete this section ❒ No, go to Part 5

If you and your child's other parent have been divorced or are legally separated, please indicate who has physical custody of your child(ren).

❒ Father ❒ Mother ❒ Other ______________________ Date Awarded:______________

Is a parent required by court decree to provide insurance? ❒ Yes ❒ No If yes, which parent? ❒ Father ❒ Mother ❒ Both

If so, what other coverage has been provided? ____

PART 5 – SIGNATURE

The above statements are true and correct to the best of my knowledge.

____

Signature of Blue Cross of Idaho Enrollee *Date*

Enrollee No:

Date: