

## OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ID Number: \_\_\_\_\_  
 Date: \_\_\_\_\_

1. Do you or any dependents have any other group health, dental or Medicare coverage?     No     Yes

**IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (1-800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

2. Please list the family members covered by the other policy and the type of coverage you have.

	<input type="checkbox"/>	Medical	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Medicare
	<input type="checkbox"/>	Medical	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Medicare
	<input type="checkbox"/>	Medical	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Medicare
	<input type="checkbox"/>	Medical	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Medicare
	<input type="checkbox"/>	Medical	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Dental	<input type="checkbox"/>	Medicare

For additional family members, attach sheet with information.  
 \* If you checked Medicare, answer number 7 on page 2.

3. Name of other policyholder. \_\_\_\_\_

Other policyholder's date of birth \_\_\_\_\_ Relationship to you \_\_\_\_\_

4. Employer name if coverage is provided through an employer. \_\_\_\_\_

5. Name of other insurance company and effective date of policy. \_\_\_\_\_ Effective Date \_\_\_\_\_

If policy is now terminated, please give termination date. \_\_\_\_\_ ID# \_\_\_\_\_

6. If there is a divorce or separation, please list who is responsible for the healthcare expenses. \_\_\_\_\_

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? \_\_\_\_\_

\*\*\*\*\* SECTION PERTAINS TO MEDICARE COVERAGE ONLY \*\*\*\*\*

7. Are you actively working?  Yes  No Begin date \_\_\_\_\_ Last day of active employment \_\_\_\_\_

8. Are you or any family members covered by Medicare?  No  Yes  
If No, please sign and date below. If Yes, please complete the information below.

•Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Medicare Number \_\_\_\_\_ Part A Effective Date \_\_\_\_\_  
Part B Effective Date \_\_\_\_\_  
Reason for Medicare (check one)  Age  Disability  ESRD date of first dialysis

•Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Medicare Number \_\_\_\_\_ Part A Effective Date \_\_\_\_\_  
Part B Effective Date \_\_\_\_\_  
Reason for Medicare (check one)  Age  Disability  ESRD date of first dialysis

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Please mail or fax this form to the correct plan listed below.\*\*\*

- State Health Plan ("ZCS" Alpha Prefix) State Health Plan: AX-B10  
ATTN: COB  
P.O. Box 100605, Columbia, SC 29260-0605  
FAX (803) 699-7675
- Federal Employee Plan/FEP ("R" Alpha Prefix) Federal Employee Customer Service  
P.O. Box 100603  
Columbia, SC 29260-9982  
FAX (803) 736-8341
- Small Group and Individual ("ZCY" Alpha Prefix) Group and Individual: AF-225  
ATTN: COB  
P.O. Box 100246, Columbia, SC 29202-3246  
FAX (803) 264-0172
- Preferred Blue® and all other BlueCross (Include name of health plan.) BlueCross BlueShield of South Carolina  
P.O. Box 100300  
Columbia, SC 29202  
FAX (803) 264-9128

Clear Form