Anthem Blue Cross and Blue Shield
Coordination of Benefits Questionnaire

Your Anthem contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the member's Blue Cross and/or Blue Shield plan immediately.

Please send this completed form with the information requested on your patient to the Blue Cross and/or Blue Shield plan of which they are a member. You can call the customer service phone number on the back of member ID card to get the address.

Policyholder Name: ______________________

Group Number: ______________ Member ID Number: ______________

SectionA — Other Insurance *If this does not apply, check "No" and skip to Section B*

Is the patient or any other member of this Anthem policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

☐ No — If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ Yes — If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark 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: ______________________

Address: ______________________

City: __________ State: __________ Zip: __________ Phone Number: __________

Dependent(s) listed on the other insurance: ______________________

Other Insurance Policyholder's Name: __________ Policyholder's Date of Birth: __________ ID Number: __________

Effective Date of Other Insurance: __________ If Cancelled, Cancellation Date: __________

Is the policy holder: ☐ Actively working for the group ☐ Inactive
☐ Retired, retirement date: __________ ☐ On COBRA, which began: __________

Policyholder's Employer: ______________________

Address: ______________________

City: __________ State: __________ Zip: __________ Phone Number: __________

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Section B — Medicare Information *If this does not apply, check "No" and skip to Section C*

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: ____________

Medicare Entitlement: ☐ Yes ☐ Disability* ☐ Yes ☐ 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: __________

Section C — Court Order Information *If this does not apply, check ""No" and skip to Section D*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ **Yes** ☐ **No**

List the name(s) of the dependent(s) that this applies to.

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/or Blue Shield Plan

Section D — Names of Dependent(s) on Blue Cross and/or Blue Shield Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder Signature **Date**