##### Premera Blue Cross logo

PO Box 91059, MS 132 Customer service: 800-676-1411

Seattle, WA 98111 Hearing impaired: 800-842-5357

Fax number: 425-918-5231

# Coordination of Benefits Enrollment Questionnaire

Dear Subscriber:

We need additional information to update our records. T he Microsoft Plans have a coordination of benefits provision and we need to know if you or your dependents have other health coverage. Please complete this questionnaire. You may fax, mail, or call customer service with the information. Please refer to the back of this form for answers to the most often asked questions regarding the coordination of benefits. Thank you for your cooperation and prompt response!

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Subscriber name and address |  | Date |  | | | |
|  |  | Member ID | |  | | |
|  |  | Group number | | | | 1000010 |
|  |  | Group name | | | Microsoft | |
|  |  |  | | | |  |

**OTHER INSURANCE INFORMATION**

Do you or any family members have any of the following:

**1.** **Coverage with Premera** (other than Microsoft)**?**  **No**  **Yes** If Yes, please complete the following line.

|  |  |  |  |
| --- | --- | --- | --- |
| SUBSCRIBER NAME | DATE OF BIRTH | SUBSCRIBER ID NUMBER | GROUP NUMBER |
| **2. Other medical, dental, prescription drug, or vision coverage?**  **No**  **Yes**  If Yes, please complete the following sections. If more than two policies, please attach additional paper or an additional form. | | | |
| **IF ANOTHER HEALTH INSURANCE PLAN PAYS FIRST, SEND US A COPY OF THEIR EXPLANATION OF BENEFITS WHEN THE CLAIM IS SUBMITTED.** | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OTHER INSURANCE COMPANY:** | | | | | | | | | | | | | | | | |
| COMPANY NAME | | | | | | | | | | | | | | | | |
| STREET ADDRESS | | | | | | | | | | | | | | | | |
| CITY | | | | | | | | | | STATE | | | | ZIP | | |
| TELEPHONE NUMBER  (     )     – | | | | | | | | | | | | | | | | |
| EFFECTIVE DATE OF COVERAGE | | | | | | | | | | | | | | | | |
| NAME OF POLICYHOLDER | | | | | | | | | | | | | | DATE OF BIRTH | | |
| POLICYHOLDER’S RELATIONSHIP TO PREMERA SUBSCRIBER | | | | | | | | | | | | | | | | |
| IS POLICY A GROUP COVERAGE?  IS COVERAGE AN INDIVIDUAL POLICY?  IS THIS COBRA COVERAGE? | | | | | | | NO | | | | YES | | | | | |
|  | | | | | | | NO | | | | YES | | | | | |
|  | | | | | | | NO | | | | YES | | | | | |
| POLICY ID # (SOCIAL SECURITY #, MEMBER #, ETC.) | | | | | | | | | | | | | | | | |
| GROUP # | | | | | | | | | | | | | | | | |
| EMPLOYER:  IS POLICYHOLDER RETIRED?  NO  YES | | | | | | | | | | | | | | | | |
| ABOVE POLICY IS FOR: | | | | | | | | | | | | | | | | |
| MEDICAL | | DENTAL | | | | VISION | | | | PRESCRIPTION DRUGS | | | | | | |
| ABOVE POLICY COVERS: | | | | | | | | | | | | | | | | |
| SUBSCRIBER | | | SPOUSE/DOMESTIC PARTNER | | | | | | | | DEPENDENT CHILDREN | | | | | |
| **OTHER INSURANCE COMPANY:** | | | | | | | | | | | | | | | | | |
| COMPANY NAME | | | | | | | | | | | | | | | | | |
| STREET ADDRESS | | | | | | | | | | | | | | | | | |
| CITY | | | | | | | | | | | | STATE | | | ZIP | | |
| TELEPHONE NUMBER  (     )     – | | | | | | | | | | | | | | | | | |
| EFFECTIVE DATE OF COVERAGE | | | | | | | | | | | | | | | | | |
| NAME OF POLICYHOLDER | | | | | | | | | | | | | | | DATE OF BIRTH | | |
| POLICYHOLDER’S RELATIONSHIP TO PREMERA SUBSCRIBER | | | | | | | | | | | | | | | | | |
| IS POLICY A GROUP COVERAGE?  IS COVERAGE AN INDIVIDUAL POLICY?  IS THIS COBRA COVERAGE? | | | | | | | | NO | | | | | YES | | | |
|  | | | | | | | | NO | | | | | YES | | | |
|  | | | | | | | | NO | | | | | YES | | | |
| POLICY ID # (SOCIAL SECURITY #, MEMBER #, ETC.) | | | | | | | | | | | | | | | | | |
| GROUP # | | | | | | | | | | | | | | | | | |
| EMPLOYER:  IS POLICYHOLDER RETIRED?  NO  YES | | | | | | | | | | | | | | | | | |
| ABOVE POLICY IS FOR: | | | | | | | | | | | | | | | | | |
| MEDICAL | | | DENTAL | | | | VISION | | | | PRESCRIPTION DRUGS | | | | | |
| ABOVE POLICY COVERS: | | | | | | | | | | | | | | | | | |
| SUBSCRIBER | | | | SPOUSE/DOMESTIC PARTNER | | | | | | | | | | DEPENDENT CHILDREN | | |

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| **3. Medicare coverage?**  **No**  **Yes** If Yes, please complete the following sections. If there is more than one member with Medicare Coverage, use a separate piece of paper. **Please** **include a copy of your Medicare card(s) for each Medicare recipient.** | | | | | | |
| NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE | | | MEDICARE ID NUMBER | PART A EFF. DATE | PART B EFF. DATE | PART D EFF. DATE |
| RETIREMENT DATE | ARE YOU ENTITLED TO MEDICARE DUE TO ONE OF THE FOLLOWING: | | DATES REQUIRED IF DISABILITY OR KIDNEY FAILURE CHECKED: | DATE OF ENTITLEMENT | FIRST DIALYSIS TREATMENT | KIDNEY TRANSPLANT |
|  | DISABILITY | KIDNEY FAILURE |  |  |  |  |
| Are you entitled to Medicare for more than one reason? If so, give the reasons for your dual entitlement. | | | | | | |

1. **If parents are divorced or legally separated, the following information is needed to determine which coverage will process claims first for dependent children**.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CHILD’S NAME | | | NAME OF PERSON  WITH CUSTODY | RELATIONSHIP TO CHILD | NAME OF PERSON WITH  FINANCIAL RESPONSIBILITY  FOR HEALTH COVERAGE  ACCORDING TO  DIVORCE DECREE | RELATIONSHIP  TO CHILD | NAME OF OTHER COVERAGE PROVIDED |
| FIRST | | LAST |
|  |  | |  |  |  |  |  |
|  |  | |  |  |  |  |  |
|  |  | |  |  |  |  |  |
|  |  | |  |  |  |  |  |

|  |  |
| --- | --- |
| It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. | SIGNATURE OF SUBSCRIBER OR SPOUSE  *X* |

**Questions and answers to help you understand Coordination of Benefits (COB)**

**What is Coordination of Benefits (COB)?**

COB is two or more health care companies working together to share the cost of health care expenses.

**Why do we coordinate benefits?**

Insurance regulations allow health care companies to coordinate benefits. These regulations allow us to keep your cost of health   
care coverage as low as possible by avoiding payment of more than the total charge of bills submitted. These rules identify one   
plan as “primary” (the company that pays first) and the other plan as “secondary” (the company that pays second.)

**Who do I submit my bill(s) to first?**

* If the patient is our Subscriber, submit to us first and the other plan second.
* If the patient is the spouse of our Subscriber, submit to the other plan first and to us second.
* If the patient is a dependent child, submit to the plan of the parent whose birthday falls **earliest in the year**. Example:   
  mother’s birth date is May 5th and father’s birth date is November 9, submit to the **mother’s** plan first.
* If the parents of the patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility  
  for health care coverage according to the divorce decree. If not stated in the divorce decree, submit bill(s) in the following   
  order:

1. To the plan of the parent with custody;
2. To the plan of the spouse of the parent with custody;
3. To the plan of the natural parent without custody; or
4. To the plan of the spouse of the parent without custody.

* If you have two coverages with us, submit each bill with both Subscriber and Group identification numbers.
* If Medicare is your primary carrier, submit your bill(s) to us with a copy of the Medicare Explanation of Benefits.
* If you are the Subscriber of more than one health care coverage, the coverage which has been effective the longest is primary.   
  Submit your bill(s) to that carrier first.
* Retiree Plans may require any non-retiree coverage to be primary.

**How do we coordinate benefits?**

* When we receive your bill(s), we determine which health care company will process your bill(s) first.
* If you submit your bill(s) with a copy of your other health care company’s denial or an Explanation of Benefits, we will use this information to process your bill(s) promptly.
* If we do not receive this information with your bill(s), we contact your other health care company to obtain the information   
  needed to process your bill(s). We always call those companies that coordinate over the telephone. This enables us to process  
  your bill(s) promptly.

Discrimination is Against the Law 
Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them  differently because of race, color, national origin, age, disability or sex. 
Premera: 
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
• Qualified sign language interpreters
• Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
• Qualified interpreters
• Information written in other languages
If you need these services, contact the Civil Rights Coordinator. 
If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator - Complaints and Appeals Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals 
PO Box 262527, Plano, TX  75026 Phone: 888-850-8526, fax: 800-889-1076, TTY: 711 Email AppealsDepartmentInquiries@Premera.com  You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019,  800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.Getting Help in Other Languages 
This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 888-850-8526 (TTY: 711).