Coordination of Benefits for Other Insurance Coverage

If you have other insurance in addition to your Primary coverage, we will need your other insurance information.
By coordinating benefits among all insurance carriers, members receive the maximum benefits available.

* indicates required fields, as applicable

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

PATIENT » *Name of Patient: _____ *Date of Birth: _____

INSURED » *Name of Insured: _____ *Phone #: _____

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

***Insurance Plan Name**: _____ ***Policy and Group** #: _____

***Does the Patient have other insurance or Medicare Coverage?**

☐ YES » Continue with form

☐ NO » Go to **Signature** section

OTHER INSURANCE CARRIER:

* Name of person who holds Other Insurance policy: _____
* Name of this person's Employer: _____
* Name of Other Insurance Carrier: _____
Insurance Carrier address: _____
Insurance Carrier phone number: _____
*Policy Number: _____ *Group Number: _____
*Beginning date of Coverage: _____ *End date of Coverage (if applicable): _____

Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ Other _____

PHARMACY

Pharmacy name: _____ Pharmacy phone number: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): _____

Relationship of other insurance member to child: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes ☐ No

Relationship of party with decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____
Name of responsible party: _____
Address: _____

Name and date of birth of both parents	Parent #1 Name: Parent #1 Date of Birth:	Parent #2 Name: Parent #2 Date of Birth:

MEDICARE:

*Name of Individual Covered by Medicare: _____
*Medicare ID#: _____
Date of Birth: _____ Date of Retirement (if applicable): _____
*Medicare Part A effective date (if applicable): _____
*Medicare Part B effective date (if applicable): _____
*Medicare Part D Prescription Drug Coverage effective date (if applicable): _____

*Eligibility Reason: ☐ Age

☐ Disability Date disability began: _____

☐ End Stage Renal Disease First date of dialysis: _____
Kidney transplant date: _____

SIGNATURE:

*Insured or Patient Name (print): _____

*Signature of Insured or Patient: _____ *Date: _____

Health Claim Transmittal

INSURED INFORMATION
Last Name_____ First Name_____ Middle Initial_____
Street Address_____ City_____ State_____ Zip_____
Student Insurance ID# or Social Security#_____
Home Phone_____ Birth Date_____

PATIENT INFORMATION (if different from above)
Last Name_____ First Name_____ Middle Initial_____
Street Address_____ City_____ State_____ Zip_____
Student Insurance ID# or Social Security#_____
Home Phone_____ Birth Date_____
Patient's relationship to student: __self __spouse __child __other

ACCIDENT INFORMATION
Type of accident: __work __auto __intercollegiate sport __intramural sport
__interscholastic sport
Type of sport_____
Details of accident_____

INJURY/SICKNESS INFORMATION
Have you suffered the same or a similar condition in the past? _____
If yes and you were treated for it, give name date and address of the physician that treated you.
_____

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER MEDICAL PROVIDER TO RELEASE ANY INFORMATION REGARDING THE MEDICAL TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
Insured signature_____ Date_____

OTHER INSURANCE INFORMATION
Name of person carrying other insurance _____
Subscriber # or Social Security # _____
Name of other carrier _____
Other insurance policy # _____
Other insurance phone # _____
Policy Holder Date of Birth _____
Insured signature _____ Date _____

STUDENT HEALTH CENTER REFERRAL
Did receive a Referral? _____
Health Center closed? _____
Was this an emergency? _____
Were you more than 50 miles from campus? _____
Other (please explain) _____