

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

Section **A** | **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			
Address	State	Zip	Phone Number

Dependent(s) listed on the other insurance		
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Other Insurance Policyholder's Name	Policyholder's Date of Birth	ID Number
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Effective Date of Other Insurance	If Cancelled, Cancellation Date
Is the policy holder: <input type="checkbox"/> Actively working for the group <input type="checkbox"/> Inactive <input type="checkbox"/> Retired, retirement date: _____ <input type="checkbox"/> 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 NoWas ESRD started as Self Dialysis or Home Dialysis? Yes NoHas 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**