COORDINATION OF BENEFITS QUESTIONNAIRE

Your insurance contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for your claims to process correctly. Please complete the information below.

Patient Name	Patient DOB	Insurance Name	Insurance ID Number

Policy Holder Name	Policy Holder DOB	Relationship to patient

What type of policy is Primary Coverage? ❑ Employer ❑ Medicaid ❑ Medicare Advantage ❑ Medicare ❑ Other

Primary Policy Holder's Employer: ______________________________

If the patient is a child or dependent – Please provide Name and birthdate of both parents:

Mother	Mother's DOB	Father	Father's DOB

Are the natural parents: ❑ Married ❑ Not Married

Section A – Other insurance - Is the patient covered by another medical insurance?

❑ **No -** If no, please sign, date and return this form to us, indicating "No other insurance." (Skip to Section B).

❑ **Yes -** If yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

What type of policy is the other coverage? ❑ Employer ❑ Medicaid ❑ Medicare Advantage ❑ Medicare ❑ Other

______________________________ ______________________________
Insurance Carrier's Name ID Number

______________________________ ____/____/____
Insurance Policyholder's Name Insurance Policyholder's Date of Birth

____/____/____ ____/____/____
Effective Date of Other Insurance If Cancelled, Cancellation Date

Is the policyholder: ❑ Actively working for the employer ❑ Inactive ❑ On COBRA, which began: ____/____/____

Secondary Policyholder's Employer: ______________________________

Section B – End Stage Renal Disease Entitlement – ESRD patients Only

First Kidney Dialysis Date	Kidney Transplant Date	Date 30 month coordination period began

Section C – Signature Required

______________________________ ______________________________
Policyholder's Signature **Date**

1001 Registration Documents

1001-0075
(03/2019)