BlueCross BlueShield of Montana

Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, Montana 59604

Customer Information Line
1-800-447-7828
bcbsmt.com

Coordination of Benefits

Date: _____

Health Plan ID: _____ **Group Number**: _____

Claim Number: _____

Please help us complete processing your claim(s) by responding to this request for information within five days. We must determine whether there is health insurance in addition to this Blue Cross and Blue Shield policy, including Medical, Dental, Vision, or Medicare. If your plan is subject to the Employee Retirement Income Security Act (ERISA), you have 45 days to respond before this claim is denied for insufficient information.

If you prefer to call with this information, or if you have a situation that cannot be adequately expressed in this form, call us toll-free at 1-800-447-7828.

A. Basic Information

1. Have you or anyone else on your policy had health insurance coverage ***in addition*** to this policy at any time in the last 12 months?
❑ No (complete Sections A and E only) ❑ Yes (complete the entire form)

2. If you have dependents on your policy, other than your spouse, are any married? ❑ Yes ❑ No (you are done with Section A)

3. Name of Married Dependent

4. Date of Marriage

B. Medicare

1. Are you or anyone else on your policy covered by Medicare?
❑ No (complete Section C) ❑ Yes (continue)

2. Medicare policy holder name

3. Medicare HIC number

4. Medicare coverage includes: (check all that apply, followed by the effective date)

	Type	*Effective Date*
❑ Part A		
❑ Part B		
❑ Part C		
❑ Part D		

Enclose a copy of your Medicare ID card

5. Is Medicare coverage because of ❑ Age ❑ Disability ❑ End-Stage Renal

6. Is the covered person retired? ❑ Yes ❑ No

7. Is Medicare the only other health insurance coverage held by you and/or your dependent(s)?
❑ Yes (skip to Section E)
❑ No (continue)

C. Other Insurance

1. Is the other insurance with Blue Cross Blue Shield of Montana?
❑ Yes (print the policy number and skip to Section D) **Policy number**: _____
❑ No (continue)

2. Insurance Company Name	**3.** Insurance Company Address	City	State	Zip
4. Insurance Company Phone	**5.** Policy Holder Name	**6.** Policy Number		Effective Date

7. Which dependents are covered?	**8.** What types of services are covered? ❑ Medical ❑ Dental ❑ Vision	**9.** Is the policy holder retired? ❑ Yes ❑ No

10. Is this an individual (rather than employer group) policy? ❑ Yes ❑ No

11. Is this a COBRA* policy? ❑ Yes ❑ No

D. Custody Insurance

1. Are you divorced or separated from the parent of any dependent child(ren) on this policy?
❑ No (skip to Section E)
❑ Yes (continue)

2. Does one parent/guardian have *full* custody of the child(ren)? ❑ Yes ❑ No

If yes, which parent/guardian		Which child(ren)	

3. Is one parent required by court decree to provide health insurance for the child(ren)? ❑ Yes ❑ No

If yes, which parent/guardian		Which child(ren)	

E. Signature

I hereby certify that the above statements are true and correct to the best of my knowledge (sign below)

Signature	Telephone Number	Date

*A COBRA policy is sometimes offered to people who lose their employer group coverage. It allows them to continue their group coverage at their own expense.