Generic COB Form
January 2016

Coordination of Benefits for Insurance Coverage

Primary Insurance Company Name: _____

If you have other insurance in addition to your primary coverage, we will need your other insurance information to send to your primary insurance company. By coordinating benefits among all insurance carriers, you will receive the maximum benefits available. (***Require Fields)**

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

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

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

Group or Claim #: _____ Subscriber / Member #: _____

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

☐ YES » Continue with form ☐ NO » Go to **Signature** section

OTHER INSURANCE CARRIER:

* Name of the Subscriber for the Other Insurance policy: _____
* Name of the Employer: _____
* Name of Other Insurance Carrier: _____
* Insurance Carrier Claim address: _____Carrier Phone #_____
*Policy #: _____ *Group #: _____

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	Mother's name: Date of Birth:	Father's name: 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): _____
*Entitlement 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: _____