

Coordination of Benefits Form

Date: _____ Insurance Company Name: _____
Patient Name: _____ Patient Social Security Number: _____
Subscriber Name: _____ Group Number: _____
Relationship of Subscriber to Patient: _____ ID Number: _____

Dear Valued Patient,

In order for Rush-Presbyterian-St. Luke's Medical Center to continue to provide exceptional healthcare, it is very important for our institution to receive payment for services rendered. To this end, our Healthcare Finance Department coordinates benefits from insurance companies if the patient is covered by more than one policy. Coordination of benefit information is required every year to account for changes in employment status. Please complete this form in its entirety so that we may determine the correct order of claims payments. If your insurance company denies your services, you will become liable. ***The top WHITE copy of this form will be retained by Rush, the bottom YELLOW copy should be mailed to your insurance company as soon as possible.***

SUBSCRIBER'S NAME (FIRST): _____ (LAST): _____
SUBSCRIBER'S BIRTH DATE: ____/____/____ IS THE SUBSCRIBER EMPLOYED? YES____ NO____
SUBSCRIBER'S EMPLOYER: _____ PHONE: _____
SUBSCRIBER'S EMPLOYER ADDRESS: _____
CITY, STATE, ZIP: _____ SUBSCRIBER SSN: _____

Do you have other Medical Insurance coverage available such as Medicare, Medicaid, CHAMPUS, policies from other employers, school, sport or travel groups?

NO, THERE IS NO OTHER INSURANCE _____ **YES, OTHER INSURANCE EXISTS** _____
(If yes, complete the following)

Name of Other Insurance Company: _____
Policy and/or ID Number: _____
Name of Policy Holder (First): _____ (Last): _____ Relationship: _____
Insurance Company Address: _____
City, State, Zip: _____ Phone: _____
Employer (for OTHER insurance): _____
Employer Address: _____
City, State, Zip: _____ Phone: _____
Effective Date: _____

The information provided above is accurate and true to the best of my knowledge.

Signed: _____ Date: _____