Rush University Medical Center

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 University 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: