Coordination of Benefits Questionnaire
- for BlueCard® Members -

The out-of-area member's contract may contain a Coordination of Benefits (COB) provision. We depend upon help from the member and/or provider to obtain accurate, up-to-date information about COB. Your assistance with this process will eliminate the need to gather the information later, thereby reducing potential claim processing delays.

Form Submission Instructions: Two Options

1. Provider Faxes Now: If you wish to have this Blue Cross Blue Shield Association form completed by the BlueCard policyholder at the time of service, please fax the completed form with the policyholder's signature to:

Highmark Blue Shield
Fax Number: 1-888-286-7880 ◄

This fax number is **for provider use only** for submission of BlueCard COB Questionnaires. Please do not give this fax number to members.

Be sure to use a fax cover sheet that includes contact information for your practice. We will electronically route the form directly to the member's Home Blue Plan.

-OR-

2. BlueCard Member Mails Following Visit: If the form is not completed during the patient visit, please ask the member to complete and mail the form as soon as possible after the visit. Members should mail the form to their Home Blue Plan using the address listed on the back of their member identification card. Their Home Blue Plan telephone number is also found on the identification card, if they should have any questions. Complete instructions for members are included in the introduction on the form.

Thank you for your assistance!

The BlueCard Program allows participating Blue Plan providers in every state to submit claims to their local Blue Plan for indemnity, PPO and managed care patients who are enrolled in an out-of-area Blue Plan. If you have any questions about BlueCard, please be sure to visit our *BlueCard Information Center* online in the Provider Resource Center.

HIGHMARK® BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

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FORM TO FOLLOW

Coordination of Benefits Questionnaire

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Your Blue Cross Blue Shield contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's Blue Cross Blue Shield plan immediately.

Call the toll-free number on your membership identification card to reach the BCBS Plan that you are a member of to either provide this information via the phone, or to obtain an address where you can submit this completed form.

BCBS Policyholder Name

BCBS Group Number | BCBS Member ID Number

Section A | Other Insurance *If this does not apply, skip to Section B.*

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

☐ **No** If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

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

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name

Address

City | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth (/ /) | ID Number

Effective Date of Other Insurance (/ /) | If Cancelled, Cancellation Date (/ /)

Is the policyholder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date: / / ☐ On COBRA, which began: / /

Policyholder's Employer

Address

City | State | Zip | Phone Number

Section B | Medicare Information *If this does not apply, skip to Section C.*

Do the policyholder and/or dependent(s) have Medicare? ☐ **Yes** ☐ **No**

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A: ___/___/___ Effective date of Medicare Part B: ___/___/___

Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:

1st Date of Dialysis for ESRD:

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of the transplant. ___/___/___

Section C | Court Order Information *If this does not apply, skip to Section D.*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ **Yes** ☐ **No**

List the name(s) of the dependent(s) that this applies to.

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the child(ren)? | Who has custody of the child(ren) more than 50% of the time?

Documentation of the court order may be requested from your Blue Cross Blue Shield plan.

Section D | Name(s) of Dependent(s) on BCBS Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
		/ /		– –
		/ /		– –
		/ /		– –

Policyholder Signature **Date**