Coordination of Benefits for Other Insurance Coverage

If you have other insurance in addition to your **Blue Cross & Blue Shield of Rhode Island** coverage, we will need your other insurance information. By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.

* indicates required fields, as applicable

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: __________________________
Insurance Carrier phone number: ___________________________
*Policy Number: ____________________________ *Group Number:

*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 <u>of both parents</u>	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:

*Insured or Patient Name (print): ___________________________________

*Signature of Insured or Patient: ___________________________________ *Date: ____________