WMC Health | Westchester Medical Center

Westchester Medical Center Health Net

The patient will enter the Facility/ Provider's Name as well as the patient's name. This can be the Patient's name or the Guarantor entering the patient's name.

aetna®

Coordination of Benefits

Name of facility/provider
Patient name

1. Do you or another family member have other health coverage that may cover this claim?
If no, please provide the information within section one, sign and date. If yes, please complete all fields, sign and

Name of Aetna subscriber		
Date of birth	Aetna member ID	Patient relationship to subscriber
Name of employer group	Effective date of coverage	

1a. Type of other coverage

☐ Other Aetna Health Plan ☐ Oth…nce ☐ Student Health ☐ Medicaid

Other health plan name	Effective date of coverage
Other health plan address	
Other health plan phone	☐ On COBRA
Patient relationship to s…	

The patient will enter Subscriber's name, this is the owner of the Insurance plan. Their Date of Birth, Member ID (Identification Number), Patient's relationship to subscriber, The subscriber's employer group and effective date of coverage. If this patient only has one insurance health plan, the patient must skip down past selection four (4) and sign the form.

2. If the patient is …

Patient's name
Patient's date of birth
Father's name and date…

3. If separated or …

Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental or other health care expenses?
☐ Yes ☐ No If yes, specify who: _____

Who has custody of the dependent child(ren)?	Who do the child(ren) live with?	How many months of the year?

4. Do you and/or another family member have Medicare?
If yes, provide the following for each family member with Medicare.

Name of Medicare beneficiary		☐ Medicare A ☐ Medicare B ☐ Both
Medicare member ID	Entitlement reason ☐ Age ☐ Disability ☐ End stage renal disease	Effective date
If entitled due to end stage renal disease, please provide:		
The date of first dialysis	☐ Home dialysis ☐ D…	Date of transplant, if applicable

The individual completing the form must sign and date. Please note, if the form is not completed accurately the form will be deemed Invalid

You can return this form to us by fax or mail:

Fax: **(866) 474-4040**

Print Name of the person completing the form	
Signature	Date

GR-68954 (4-18)