WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

The patient MUST select ONE of the following. Each selection has a required "Next Step" highlighted in yellow.

Yes- Complete Section 2-7

Medicare only/ ESRD- Complete Section 3,5 and 7

Medicaid/Champus/Tricare- Skip to Section 7

No-Skip to Section 7

Empire BLUECROSS BLUESHIELD

Subscri
Subscri

COORDINATION OF BENEFITS

Instructions: Please fill out **all applicable** sections completely by filling in the applicable circle(s) with each section and **print clearly in black or blue ink** in order for us to quickly and accurately process your request.

Section 1 – Member Insurance Information

Are any family members that are covered under the policy above covered under any other group health insurance policy (currently or during the past 2 years)?

Yes	Medicare Only / ESRD	Medicaid / CHAMPUS/ TRICARE	No
Complete sections 2 – 7	*Complete sections 3 5 and 7*	*Skip to section 7*	*Skip to section 7*

Section 2 – Other Insurance Information

Indicate name of other insurance carrier (fill in only one)

(NOTE: If more than one other coverage, please provide the other carrier information from this section on an additional page.)

O Aetna / US Healthcare O Blue Shield of NENY O CDPHP O CIGNA O GHI

O HIP O Horizon BC of NJ O MVP O Oxford O United Health Care

O Other (Name of Carrier)

Customer Service Telephone Number:

In Section 3: The Subscriber will enter the Primary Contract Holder Name, The Member ID Number, Group Number, select the patient's relationship to subscriber and the date of retirement if the patient is retired.

Effective dates of the other coverage:

Effective Date (mmddyyyy)

Termination Date (mmddyyyy) *(if applicable)*

Section 3 – Primary Contract Holder Information of Other Insurance

Primary Contract Holder on the policy indicated in section 2: Last Name First Name

Identification Number or Medicare ID number: *(Include all letters and prefix)*

Group Number: *(If Available)*

Relationship of this contract holder to the contract holder listed at the top of this form:

O Self O Spouse O Dependent O Ex-Spouse or Legally Separated Spouse O Other

If relationship is "SELF" or "SPOUSE", indicate employment status

O Actively working with employer offering other coverage

O Not Actively Working/Long Term Disability

O Retired from employer providing other coverage

If retired, date of retirement:

WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

Section 4: The Subscriber will choose if they are enrolled in Medicare, the Medicare coverage type and the reason the patient receives Medicare Coverage.

Subscriber Name:
Subscriber Identification Number:

Section 4 – Medicare Enrollee Information

Name of Beneficiary	Coverage Type	Effective Date (mmddyyyy)	Medicare Entitlement Reason		
	O Part A		O Age	O Disability	O Kidney Failure Date of 1st treatment: ___/___/___
	O Part B				
	O Part D				
	O Part A		O Age	O Disability	O Kidney Failure Date of 1st treatment: ___/___/___
	O Part B				
	O Part D				

Section 5 – Covered Persons

Complete the following information for all persons covered under the other policy – including the subscriber in section 3 (attach a separate sheet if additional space is needed)

	Name (first and last name)	section 3 (i.e., self, spouse, child, step-child, custodial parent)	Date of Birth (mm/dd/yyyy)	Fill in if covered by Medicare
a)		SELF		
b)				
c)				
d)				

Section 3: The Subscriber is to list all of the dependents covered under the Health Insurance starting with themselves.

Section 6 – Dependent Children

other policy and the parents are divorced or legally separated)

If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the Court Order — O Mother O Father O Joint Agreement O Legal Guardian

If there is no legally binding agreement, who has primary custody (custodial parent)? — O Mother O

Which dependent children in section 5 above does this — O a O

IF the patient is a dependent, the subscriber MUST complete and respond to EACH question in Section 6

Section 7 – Co… …er Signature

Insurance Fraud Statement: I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five

Signature _____ Date Signed _____

Daytime Telephone Number: ___ - ___ - ____

This Coordination of Benefits questionnaire may be completed via:

- **Internet** – logon to www.PLAN_SPECIFIC_SITE.com
- **US Mail** – return this form in the enclosed pre-addressed envelope
- **Telephone** – contact your Customer Service Center at the toll-free number liste… …e back of your identification card during normal business hours.

The individual completing the form must sign,date and a telephone number that they can be reach at. Please note, if the form is not completed accurately the form