



Westchester Medical Center

Westchester Medical Center Health Network

Coordination of Benefits (COB) - JOB AID

Health Insurances: **Aetna, Cigna, Emblem, Oxford and United Healthcare.**

It is the responsibility of the Registration Representative to ensure that they are capturing **COB FORMS** for all **PEDIATRIC PATIENT'S (21 & younger)** and all **MARRIED ADULTS** who have any of the above listed insurances. The COB is only required if the patient is only covered under **ONE** insurance coverage. All COB Form **MUST** have a Patient Label prior to scanning/uploading into the patient record. The forms must be scanned under Consents & Rename COB.

Please see below an example of a complete form:

aetna® **Coordination of Benefits**

Name of facility/provider
Patient name

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.

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 date.

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 ☐ Other Insurance ☐ Student Health ☐ Medicaid
Other health plan name **Effective date of coverage**
Other health plan address
Other health plan phone
Patient relationship to subscriber
☐ On COBRA

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 your child:
Patient's name
Patient's date of birth
Father's name and date

3. If separated or divorced:
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
If entitled due to end stage renal disease, please provide the date of first dialysis
☐ Dialysis in facility/dialysis center

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:

Aetna
PO Box 981106
El Paso, TX 79998-1106
Fax: (866) 474-4040

NOTE: Please don't return this form without a valid signature and date.
Print Name of the person completing the form
Signature **Date**