WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

UnitedHealthcare Oxford

The patient will enter the Subscriber's Name, Member ID Number, select and complete the subscriber's employment information. If the patient is covered under their spouse, the Spouse's employment information MUST be filled out.

Coordination of Benefits

Please submit this form with all supporting documentation.
Mailing Address: Coordination of Benefits Department, P.O. B

SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Subscriber Name: _____ ID Number: _____

Subscriber Employment Information (Please check the appropriate boxes)

Actively at Work: ❑ Yes ❑ No Total number of employees at company is: ❑ 1-19 ❑ 20-99 ❑ 100+

Retired: ❑ Yes ❑ No Date of Retirement: __/__/__

Spouse's Employment Information

Spouse's Name: Spouse's Date of Birth:

Spouse's Current Employer/Company Name: _____

Spouse's Social Security Number: _____

Actively at Work: ❑ Yes ❑ No Retired: ❑ Yes ❑ No Date of Retirement: __/__/__

COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part A1, then sign and date the form.
- No other coverage, please complete Part A2, then sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, then sign and date the form.
- Medicare coverage, please complete Part C, then sign and date the form.

PART A

1. Other Coverage (list each separately)

Carrier Name: _____ Carrier Address: _____

Policy ID: _____ Group ID: _____ Telephone #: _____

Subscriber's Name: _____ Subscriber's SS #: _____

Rx BIN: _____ Rx PCN: _____ Rx Group: _____

Policy Effective Dates: Start __/__/__ End __/__/__ ❑ Single ❑ Subscriber & Spouse ❑ Subscriber & Dependents ❑ Family

Coverage Type:
(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ COBRA ❑ Other

Carrier Name: _____ Carrier Address: _____

Policy ID: _____ Group ID: _____ Telephone #: _____

Subscriber's Name: _____ Subscriber's SS #: _____

Rx BIN: _____

The patient will select a reason for No Other Coverage

Policy Effective Dates: Start __/__/__

Coverage Type:
(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ [illegible] ❑ Other

If the other coverage is no longer in effect, you must enclose documentation from the former carrier indicating the date the policy was terminated

2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason: ❑ Not married

❑ Benefits not offered ❑ Unemployed ❑ Self-employed ❑ Waived, as of: __/__/__

❑ Part-time employee (not eligible for benefits) ❑ Waiting period, eligible for coverage on: __/__/__

❑ Other, please explain: _____

Please turn over

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COVERAGE INFORMATION (Continued) Please Print

PART B

Please complete this section if you are divorced, legally separated, or a single parent, and you have dependent children covered under this plan.

1. Does the other biological parent of your dependent children provide health benefits? ❑ Yes ❑ No

   Name of other biological parent: _____ Birth date: / /

   If yes, please provide the following information:

   Name of other health plan: _____

   Policy #: _____

   Subscriber's SS #: _____

   Which children are covered? _____

2. With which parent does the child primarily reside? _____

   If divorced, check one of the following:

   ❑ Divorce decree stipulates other parent must provide health ben

   ❑ Divorce decree stipulates joint custody*

   ❑ Divorce decree does not stipulate any special provisions* Nam

   ❑ Other, please explain: _____

*A copy of the section of the court decree pertaining to health coverage or

Part B:

Section 1: The Subscriber will select if the patient's other biological parent provides the patient with health insurance. The other parent's date of birth, the parent's insurance information such as Policy number, Subscriber's SSN and which children are covered.

Section 2: Is where you will enter which parent the patient primarily resides with.

PART C

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of Member eligible for Medicare: _____

Effective Dates of Medicare:

Part A: / / Part B: / / Part D: / /

Reason for Medicare coverage (please check one):

❑ Age 65 or older

❑ Disability, due to: _____

❑ End Stage Renal Disease

Date Dialysis Treatment Bega

Name of Member eligible for Medicare: _____

Effective Dates of Medicare:

Part A: / / Part B: / / Part D: / /

Reason for Medicare coverage (please check one):

The individual completing the form must print, sign, date and supply their subscribers Identification Number. Please note, if the form is not completed accurately the form will be deemed Invalid

SUBSCRIBER SIGNATURE

I certify that the above information is co nderstand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to vide complete and accurate information may result in a delay in the payment of

Print Your Name: _____

Signature: _____ Date: _____

ID Number: _____