Coordination of Benefits Questionnaire

Instructions

Provide the coverage information for each family member covered under your health plan.

You'll need to submit to Ambetter Health, ATTN: Member Advocate, 5900 E. Ben White, Austin, TX 78741.

Section 1: Health plan information

Relationship	Name	Date of Birth (DOB)	Covered by another plan?
Self (Primary subscriber)			☐ Yes ☐ No
Spouse			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No

- If no one is covered by another plan, go to **Section 4** to sign and submit the form.
- If anyone has another plan, complete **Section 2**. Also complete **Section 3** if there's Medicare coverage.
- If there is more than one additional plan, provide the information in a separate copy.

Section 2: Other health plan information (Including Medicaid/CHIP)

Primary subscriber name _____ Primary subscriber DOB _____

Member ID / policy number (Include letters) _____ Group number _____

Health plan name _____ Health plan address _____

City _____ State _____ ZIP _____

Health plan phone number _____ Coverage start date _____ Coverage end date _____

Employer name _____ Subscriber is: ☐ Active ☐ Retired ☐ on COBRA

Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare

List each person covered by this plan:

Spouse _____ Dependent _____

Dependent _____ Dependent _____

Dependent _____ Dependent _____

A. If the other plan covers a child, provide:

Mother's name _____ DOB _____ Father's name _____ DOB _____

B. If parents are separated, divorced, or not married, list:

Child resides with _____ Relationship _____

Individual with custody _____ Relationship _____

C. Is there a court order establishing responsibility for health care coverage? '

☐ No ☐ Yes

If yes, provide the following: Responsible party _____ Relationship _____

If multiple children have coverage under another plan — and the information above is different, provide in a separate copy.

Section 3: Medicare coverage information

Medicare subscriber name _____ Medicare ID number _____

- ☐ Part A – Effective date _____
- ☐ Part B – Effective date _____
- Entitlement reason:
  - ☐ Age
  - ☐ Disability
  - ☐ End stage renal disease
    - If due to end stage renal disease, provide the first date of dialysis _____
    - ☐ Home dialysis ☐ Facility or dialysis center
    - Date of kidney transplant, if applicable _____

Section 4: Signature

_____ _____

Name of person completing the form | Relationship to primary subscriber

_____ _____

Signature | Date