

COORDINATION OF BENEFITS FORM

Before the Health Plan can process claims for you and your dependents, we need information regarding your other health insurance, if any. This information is required so that we can coordinate benefit payment with your other insurance. A separate **Coordination of Benefits Form** should be completed for you and each of your covered dependents.

If you are covered by Medicare or another group insurance plan and the other plan is your primary plan, you must file your claim with the other plan first. Once the other plan processes your claim, you can send a copy of the itemized bill and the Explanation of Benefits to our office.

If you are covered by Medicare or another group insurance plan and the other plan is your secondary plan, you should file your claims with us first.

If you have any questions regarding determining which plan is your primary plan, please contact the Health Plan office.

Participant Name: _____

Social Security Number: _____

Are you or any of your dependents covered by any other group insurance or medical service plan? Yes No

Are you or any of your dependents covered by Medicare? Yes No

If you answered yes to either of the previous questions, please provide the following for each group plan:

Name of Insured: _____

Name of Insurance Plan: _____

Policy Number: _____

Effective Date: _____

Address Where Claims are Sent: _____

Address of Insured's Employer: _____

Please return this form to the Health Plan office by mail or fax it to (323) 782-9287.