



Blue Cross and Blue Shield of Oklahoma

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Coordination of Benefits Questionnaire

PLEASE CORRECT THE ADDRESS SHOWN AT LEFT, IF NECESSARY

BLUELINC'S ID NO.:

Dear Subscriber:

Your membership agreement requires us to coordinate benefits for all family members to determine primary and secondary responsibility for claims payments. Failure to complete this form may result in denial of benefits under this agreement. Please return this form within 45 days in the enclosed envelope.

Is anyone who is covered by your BlueLincs HMO plan also covered under another health care policy or Medicare?

CHECK ONE: NO (sign and return) YES (provide complete information below)

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SECTION 1. - OTHER INSURANCE INFORMATION

Name of policy holder who has other group health insurance policy. (For Medicare only, skip to Section 3.)

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE (MO., DAY, YEAR)	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER	
NAME AND PHONE NUMBER OF OTHER POLICY HOLDER'S EMPLOYER		NAME OF OTHER INSURANCE CARRIER			
		TYPE OF OTHER COVERAGE MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> DRUGS <input type="checkbox"/>		PHONE NUMBER ()	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED/ SEPARATED	PHONE NUMBER ()	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	CANCELLATION DATE

LIST THE NAMES OF YOUR FAMILY MEMBERS WHO ARE COVERED BY THE POLICY INDICATED IN SECTION 1 ABOVE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)	NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YEAR)

SECTION 2. - DIVORCE/SEPARATION INFORMATION

If a dependent child not mentioned above has coverage resulting from a divorce or separation, complete this section.

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MO., DAY, YR.)	PARENT WITH PRIMARY CUSTODY (CHECK ONE)	IS THERE A COURT ORDER FOR PAYMENT OF CHILD'S HEALTH CARE EXPENSE?	IF YES, NAME OF PARENT WITH PRIMARY RESPONSIBILITY	NAME AND PHONE NO. OF INSURANCE CARRIER
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)		
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)		
		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT	<input type="checkbox"/> NO <input type="checkbox"/> YES (ATTACH COPY)		

SECTION 3. - MEDICARE INFORMATION

List any family member who is eligible for Medicare benefits and is also covered under BlueLincs.

NAME OF FAMILY MEMBER (LAST, FIRST MIDDLE)	DATE OF BIRTH (MO., DAY, YR.)	MEDICARE ID NUMBER	PART A EFFECTIVE DATE (M/D/Y)	PART B EFFECTIVE DATE (M/D/Y)	REASON FOR MEDICARE ELIGIBILITY	ACTIVELY EMPLOYED
					<input type="checkbox"/> AGE 65 OR OLDER <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME AND PHONE NUMBER OF EMPLOYER						
					<input type="checkbox"/> AGE 65 OR OLDER <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME AND PHONE NUMBER OF EMPLOYER						
YOUR SIGNATURE			DATE			