



**BlueCross BlueShield  
of Nebraska**

A Not-For-Profit Mutual Insurance Company and an Independent Licensee  
of the Blue Cross and Blue Shield Association.

7261 Mercy Road  
Omaha, Nebraska 68180-0001  
www.bcbsne.com

Coordination of Benefits (COB)  
Omaha 390-1840  
Toll Free 800-462-2924  
Fax 402-392-4126

March 23, 2007

I.D. No.:  
**OC COQ**

Dear Member:

Your group coverage contains a Coordination of Benefits (COB) provision. This provision applies when more than one insurance plan provides benefits. So we can better serve you, we update this information annually. Please complete this questionnaire and return it within 30 days.

**Processing of claims submitted under your contract is dependent upon your response.**

Are you (member):

Employed:  Not Employed:  Retired:  Date of Retirement: \_\_\_\_\_

Is your spouse:

Employed:  Not Employed:  Retired:  Date of Retirement: \_\_\_\_\_

**Is there any other medical, dental or Medicare coverage available to you, your spouse or dependent children? (check below)**

Yes  We/I have Medicare coverage. Please complete **Section I** on the back of this form, sign and return.

Yes  We/I have other medical insurance. Please complete **Section II** on the back of this form, sign and return.

Yes  We/I have other dental insurance. Please complete **Section II** on the back of this form, sign and return.

No  We/I have no other medical/dental insurance or Medicare coverage. Please sign and return.

If you have any questions regarding this form, please call our office at 402-390-1840 or 1-800-462-2924.

**Please sign here:**

**I certify the information provided is complete to the best of my knowledge.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Sincerely,

COORDINATION OF BENEFITS DEPARTMENT  
COB

## Section I Medicare Information

MEDICARE	HEALTH INSURANCE
<b>1-800-MEDICARE (1-800-633-4227)</b> <small>NAME OF BENEFICIARY</small> _____	
<small>MEDICARE CLAIM NUMBER</small> _____	<small>SEX</small> _____
<small>IS ENTITLED TO</small> <b>HOSPITAL (PART A)</b> _____	<small>EFFECTIVE DATE</small> _____
<b>MEDICAL (PART B)</b> _____	

**Enter All The Information As It Appears On Your Medicare Card For Each Covered Person**

MEDICARE	HEALTH INSURANCE
<b>1-800-MEDICARE (1-800-633-4227)</b> <small>NAME OF BENEFICIARY</small> _____	
<small>MEDICARE CLAIM NUMBER</small> _____	<small>SEX</small> _____
<small>IS ENTITLED TO</small> <b>HOSPITAL (PART A)</b> _____	<small>EFFECTIVE DATE</small> _____
<b>MEDICAL (PART B)</b> _____	

I have Medicare because I am:  
 65 or older     Disabled     ESRD  
 I am:  an Active Employee  
 Retired: Date of Retirement: \_\_\_\_\_

I have Medicare because I am:  
 65 or older     Disabled     ESRD  
 I am:  an Active Employee  
 Retired: Date of Retirement: \_\_\_\_\_

Medicare Part D:  YES     NO  
 If Yes, Part D Carrier Name: \_\_\_\_\_  
 Phone No.: \_\_\_\_\_

Effective Date: \_\_\_\_\_

## Section II Other Insurance Information

\_\_\_\_\_  
 Name of Policyholder (first & last)                      Date of Birth                      Identification Number of Other Insurance

\_\_\_\_\_  
 Employer's Name                      Street Address                      City                      State                      Zip Code

\_\_\_\_\_  
 Name of Other Insurance Co.    Address                      City                      State                      Zip Code                      Phone Number

Type of Coverage(s):  
 Hospital     Physician/Medical     Prescription Drug     Dental    Effective Date: \_\_\_\_\_

TriCare Active Duty:  
 Standard Option Date: \_\_\_\_\_    Prime Option Date: \_\_\_\_\_    Retirement Date: \_\_\_\_\_

Type of Coverage:  Single     Family    Insured's Social Security Number: \_\_\_\_\_

Name of member covered by this plan	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Child Custody Information:

Insurance regulations stipulate which health plan will process claims first when coordinating benefits for dependent children whose parents are divorced, legally separated or never married. A court order could change who is the primary insurance.

Which parent has been ordered by the court to provide insurance? \_\_\_\_\_

**\*Please enclose a copy of the court order if we have not previously received it.**

Who has custody of the child(ren)? \_\_\_\_\_