Harvard Pilgrim Health Care

Coordination of Benefits Questionnaire

Name: _____ Date: _____

Address: _____ HPHC ID#: _____

_____

Thank you for receiving your health insurance coverage through Harvard Pilgrim. Your coverage contains a provision that is required by State and Federal regulations to coordinate medical/dental and Medicare benefits for members who are covered by any other health and/or dental insurance. **In order to process claims, Harvard Pilgrim needs the following information from you. Please help us by filling out this form.**

Are you or any other member of this policy covered by another medical/dental or Medicare insurance policy or any other Harvard Pilgrim policy?

- ◯ No If No, please complete **section D**, sign, date and return this questionnaire to us indicating "No Other Insurance."
- ◯ Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

A Other Insurance Information *(If this doesn't apply skip to Section B)*

Check those that apply: ◯ Other Health Insurance ◯ Dental Insurance

What type of policy is this? ◯ Group ◯ Individual Policy ◯ Student policy ◯ Medicare Supplemental

Other Insurance Carrier's Name: _____

Address: _____ Phone #: _____

Other Insurance policyholder's Name: _____ Date of Birth ____/____/____

Policy/ID# _____ Effective Date _____/____/____ If Cancelled, Cancellation Date ____/____/____

Is the policyholder:

◯ Actively working for the group ◯ Inactive ◯ Retired, retirement date ____/____/____

◯ COBRA, which began ____/___/____ ◯ Non-group/Direct pay

Policyholder's Employer: _____

Dependent(s) listed on the other insurance:	**Effective or Cancel Date, if different from policyholder**
_____	_____ / _____ / _____
_____	_____ / _____ / _____
_____	_____ / _____ / _____
_____	_____ / _____ / _____

B Court Order Information *(If this doesn't apply skip to Section C)*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? Yes / No

Name of dependent(s) that this applies to: _____

If yes, who is the person(s) listed to maintain health coverage: _____

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

What is the relation to the child(ren)? _____

Who has custody of the child(ren) more than 50% of the time: _____

Insurance regulations now stipulate which health insurer will process claims first during coordination of benefits for dependent children when parents are divorced or legally separated. The insurer covering the person with custody of the child or the person who was given financial responsibility for coverage by a court decree will process the claims first.

You must provide us with a copy of the divorce decree, the custodial parent's name, and address and phone number so we can determine the correct order of benefits.

C Medicare Beneficiaries Information *(If this doesn't apply skip to Section D)*

Subscriber Information

Are you retired? Yes / No If yes, when ___/___/___

Are you currently working? Yes / No

Name of Employer (if applicable) _____

Medicare #, including alpha character(s): _____

Effective date Medicare part A __/___/___

Effective date Medicare part B ___/___/___

Medicare Entitlement: ○ Age ○ Disability* ○ ESRD*

*Disability or ESRD please provide the following:

1st Date of Disability ___/___/___

1st Date of Dialysis for ESRD: ____/____/____

Was ESRD started in a facility Yes / No

Name of facility: _____

Facility phone #: _____

Was ESRD started as Self Dialysis /Home Dialysis Yes / No

Has a transplant been performed? Yes / No

If yes, please provide date of transplant ____/____/____

Spouse/dependent Information

Are you retired? Yes / No If yes, when ___/___/___

Are you currently working? Yes / No

Name of Employer (if applicable) _____

Medicare #, including alpha character(s): _____

Effective date Medicare part A ___/___/____

Effective date Medicare part B ___/___/___

Medicare Entitlement: ○ Age ○ Disability* ○ ESRD*

*Disability or ESRD, please provide the following:

1st Date of Disability ___/___/___

1st Date of Dialysis for ESRD: ____/____/____

Was ESRD started in a facility Yes / No

Name of facility: _____

Facility phone #: _____

Was ESRD started as Self Dialysis /Home Dialysis Yes / No

Has a transplant been performed? Yes / No

If yes, please provide date of transplant ____/____/____

D Name(s) of Dependent(s) on the HPHC Policy

Name	Relationship	Date of Birth
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

We value your Harvard Pilgrim membership and thank you for helping us by filling out this form. If you have any questions, please contact the Coordination of Benefits department at (888) 888- 4742 ext 38999 and a representative will assist you.

I hereby certify that the above information is true and correct to the best of my knowledge.

Policyholder/Member Signature: _____ Date: ____/____/____