Anthem Blue Cross and Blue Shield *and Its Affiliated HMOs*
COORDINATION of BENEFITS QUESTIONNAIRE

Covered Person's Name _____ Covered Person's Identification Number _____

Are you, your spouse or any dependent(s) covered by another health insurance plan or **Medicare**? (If the only other coverage is Tricare or Medicaid please check NO)
NO___ (If no one on this policy is covered by any other insurance or **Medicare,** please skip to Section 3)
YES___ (If YES, compile Section 1 for other insurance carriers and Section 2 for **Medicare** policies)

SECTION 1 – OTHER HEALTH INSURANCE OR HEALTH PLAN INFORMATION

If you answered YES to the question above, please refer to the other carrier's insurance card to complete this section and/or the **Medicare** section if applicable.

(A) Other Insurance Covered Person's name _____ Date of Birth ___/___/___ Policy No.:_____

(B) Health Insurance Company name or name of group health plan _____ Insurer or Administrator's Phone # (___)_____Group # _____ Effective Date: ___/___/___ Cancel date: ___/___/___

(C) Type of Coverage: Medical _____ Dental _____ Drug _____Vision _____ Hearing _____

(D) Please list the names of those covered under the other health plan:

1)_____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

(E) If there is a court decree allocating responsibility for any dependent's coverage, please attach a copy of it and provide the Name of custodial parent: _____

Name(s) of the dependent(s) covered: _____

Name of the parent who has medical responsibility under the terms of the court decree: _____

SECTION 2 – MEDICARE INFORMATION

If Medicare covers you, your spouse or any dependent(s), please refer to your Medicare card and complete the section below.

Name of Medicare Cardholder	Medicare Claim Number	Effective Dates for Each PART	Medicare Entitlement Reason (Circle One)
		A: __/__/__ B: __/__/__ D: __/__/__	Age Disability *ESRD
		A: __/__/__ B: __/__/__ D: __/__/__	Age Disability *ESRD
		A: __/__/__ B: __/__/__ D: __/__/__	Age Disability *ESRD

*If kidney or renal failure is the primary reason for Medicare, please provide date of first dialysis treatment: ___ / ___/ ___ and transplant date(s), if applicable: ___ /___ / ___ ___ /___ / ___ ___ /___ / ___

Are you or your spouse actively working? (If YES, please complete the employment information.)
You: NO___ YES___ Full-Time___ Part-Time___ Employer_____ Phone # (___)_____
Spouse: NO___ YES___ Full-Time___ Part-Time___ Employer_____ Phone # (___)_____

If you or your spouse are not actively working, have either of you retired? (If YES, please complete the retirement and former employer information.)
You: NO___ YES___ Retirement Date___/___/___ Employer_____ Phone # (___)_____
Spouse: NO___ YES___ Retirement Date___/___/___ Employer_____ Phone # (___)_____

SECTION 3 - CERTIFICATION

I certify that the above information is true and correct to the best of my knowledge:
Policyholder's Signature:_____ Daytime Phone #(____)_____Date:___/___/____

If you have any questions or require assistance with completing this form,
please call the Member Services number printed on the back of your Anthem member Identification card.

Anthem Blue Cross and Blue Shield • COB Department • PO Box 27401 • Richmond, VA 23279-7401
• Phone: 1 (800) 533-1120 •

Anthem

Revised 05/2009