Coordination of Benefits Questionnaire

MHHP POLICYHOLDER NAME: ____________________________

POLICYHOLDER DATE OF BIRTH: ________________________

MHHP MEMBER ID #: ____ __________ _____ ____

Your Memorial Hermann Health Plan contract contains a Coordination of Benefits (COB) provision. If you or your dependents have other insurance, completion of this form is required by Memorial Hermann Health Plan in order for us to process your claims accurately. We appreciate your prompt reply. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the COB Coordinator at 346-512-2120. *If an additional COB form is needed, refer to https://healthplan.memorialhermann.org/members/resource-center to locate the form in the 'Member Documents' section.*

OTHER INSURANCE:
Are you or any other member of this Memorial Hermann Health Plan policy covered by another medical or dental insurance policy or any other Memorial Hermann Health Plan policy?

☐ No If *No*, please sign and date Section A and return this questionnaire to us.

☐ Yes If *Yes*, please complete all the fields below that pertain to the member(s) that has the other coverage.

Section A *(If additional space is needed, please use the back of this form).*

NAME(S) OF POLICY SUBSCRIBER _________________________________

NAME(S) OF DEPENDENT(S) ON MEMORIAL HERMANN HEALTH PLAN POLICY

Name	Relationship	Date of Birth	Social Security # (Optional)
________________________	________________	_____/_____/______	_______ - _____ - _________
________________________	________________	_____/_____/______	_______ - _____ - _________
________________________	________________	_____/_____/______	_______ - _____ - _________
________________________	________________	_____/_____/______	_______ - _____ - _________
________________________	________________	_____/_____/______	_______ - _____ - _________

Policyholder Signature: ___________________________________ **Date:** ______/_____/______

Section B Other Group Coverage *(For additional policies, use a separate COB form).*

Check those that apply: ☐ Other Health Insurance Policy or Group # _________________________________

What type of policy is this? ☐ Group ☐ Individual ☐ Student ☐ Retiree Plan ☐ Part D Only

Other Insurance Carrier's Name: ______________________ Phone #: ____________________

Address: ____________________________________ City, State, Zip: ___________________

Dependents(s) listed on the other insurance:	Effective Date	End Date
_________________________________	____/____/_____	____/____/_____
_________________________________	____/____/_____	____/____/_____
_________________________________	____/____/_____	____/____/_____
_________________________________	____/____/_____	____/____/_____
_________________________________	____/____/_____	____/____/_____

MHHP Policyholder Name: ________________________

MHHP Member ID #: _______________________

Other Insurance Policyholder's Name: ______________________________________

Policyholder's Date of Birth: ____ /_____/_____ ID # _____________________________________

Effective Date of Other Insurance: _____/_____/______ If Ended, End Date: _____/______/______

Is the policyholder:

☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: ____/_____/______

☐ On COBRA, which began: ______/_____/_______

Policyholder's Employer: ____

Employer's Address: ____

City, State, & Zip: ____

Section C Medicare Coverage *(For additional policies, use a separate COB form).*

MEDICARE INFORMATION: Type: ☐ Traditional Medicare ☐ Medicare Advantage ☐ Med Supplement

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare: __________________________________

Medicare Number, including alpha character(s): _____________________________

Effective Date of Medicare Part A ______/____/______ Effective date of Medicare Part B: _____/____/______

Effective Date of Medicare Part D ______/____/______

Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for 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

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If *yes*, please provide the date of the transplant. _______/____/______

Section D

COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ No ☐ Yes

List the name(s) of the dependent(s) that this applies to. ____

If yes, who is the person(s) listed to maintain health coverage? ______________________________

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

Who has custody of the child(ren) more than 50% of the time? _______________________________

Documentation of the court order may be requested from your Memorial Hermann Health Plan.