There's hope. There's help.®

Coordination of Benefits Questionnaire

Date	Patient Name:
/ /	

Section 1
Do you have coverage through another group health plan? □ Yes □ No
If so, are you covered as an active employee or retiree?
Please indicate the name of the insurance carrier and effective date:

Section 2	
Does your spouse have group coverage through his/her employer? □ Yes □ No	
Name of Spouse's insurance carrier:	
Insurance Phone Number:	
Group/Policy Number:	Insured ID/SSN:
Effective Date:	Termination Date:
Family or individual coverage	

Section 3 - If the patient is under the age of 18, please complete the following:
Is there a court decree stating financial responsibility? □ Yes □ No
Who has the responsibility?
Who has custody of the child?
Does anyone other than the natural parents carry insurance on the dependent(s)? □ Yes □ No
If yes, please provide name of:
Policy Holder:
Insurance Carrier:
ID/SSN:
Phone Number:

Section 4	
Are you covered under Medicare? □ Yes □ No	
Name and date of birth of person(s) covered:	
Medicare ID#:	Is Medicare due to disability? □ Yes □ No
If yes, please list diagnosis (type of illness)	

I certify that the above information is correct.

Patient Signature: _____ Date/Time _____

Staff Signature: _____ Date/Time _____