



**Coordination of Benefits  
Questionnaire**

Self Pay, No Insurance

Policy Name \_\_\_\_\_

Group Number \_\_\_\_\_ Member ID Number \_\_\_\_\_

**Section A | Other Insurance** *If this does not apply, skip to Section B.*

**No** If No, please complete 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.

Mark those that apply:  Other Health Insurance  Other Dental Insurance\*  
\*If only Dental, not necessary to complete Section A.

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

Other Insurance Carrier's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_

Dependent(s) listed on the other insurance \_\_\_\_\_

Other Insurance Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Effective Date of Other Insurance \_\_\_\_\_ If Canceled, Cancellation Date \_\_\_\_\_

Is the policyholder:  Actively working for the group  Inactive  
 Retired: retirement date: \_\_\_\_\_  On COBRA, which began: \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_



**Section B | Medicare Information**

*If this does not apply, please make sure portion before Section A is complete.*

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: \_\_\_\_\_

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 Home Dialysis or Peritoneal Dialysis?  Yes  No

Has a transplant been performed?  **Yes**  **No**

If yes, please provide the date of the transplant: \_\_\_\_\_