Patient Name: _____ DOB: _____

RENAL ASSOCIATES of West Michigan, P.C.

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

Patient Name: _____ DOB: _____

RENAL ASSOCIATES of West Michigan, P.C.

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: _____