PREMERA | BLUE CROSS

Other Coverage Questionnaire

PO Box 91059
Seattle, WA 98111

Customer Service: 800-722-1471 | TTY: 711

Dear Subscriber:

To ensure your claims are processed accurately and on time, we need to confirm whether you have other health coverage. Please complete this form, and if you have any questions while filling it out, call the customer service number on the back of your ID card or message our Customer Service team through your secure inbox.

For answers to frequent questions about how benefits are coordinated, please refer to page 3. If you need help filling out the form, please talk to your employer or contact our Customer Service Department.

If there is a child custody court order that affects insurance coverage, please complete a Child Custody Questionnaire. This helps us determine which order each insurance plan should handle claims for the children.

Subscriber Name and Address	

Date	
Member ID	
Group number	
Group name	
Service date(s)	
Claim number	

OTHER INSURANCE INFORMATION: Do you or any family members have any of the following?

Section A. Other coverage

Do you have other coverage, other than that listed above? Select one.

❍ Yes. Continue to Section B.
❍ No. Skip to Section C.

Section B. Subscriber information

Subscriber name		
Date of birth (mm/dd/yyyy)	Subscriber ID number	Group number

Section C. Medicare coverage

Do you have Medicare coverage? Select one.

❍ Yes. Continue to Section D.
❍ No. Skip to Section E.

Section D. Medicare information

- If there is more than one member with Medicare Coverage, use a separate piece of paper.
- **Please include a copy of your Medicare card(s) for each Medicare recipient.**

Name of family member with Medicare coverage	Medicare ID number	Last date employed
Part A effective date (mm/dd/yyyy)	Part B eff. date (mm/dd/yyyy)	Part C eff. date (mm/dd/yyyy)

Are you entitled to Medicare due to disability? Select one. ❍ Yes. Complete the date field here. →→ ❍ No. Go to the next question.		Date of entitlement
Are you entitled to Medicare due to kidney failure? Select one. ❍ Yes. Complete the date fields here. →→ ❍ No. Go to the next question.	Date of first dialysis treatment	Date of kidney transplant
Are you entitled to Medicare because you are age 65 or over? I ❍ Yes ❍ No		

Section E. Other coverage

Do you have other medical, dental, vision or prescription drug coverage? Select one.
❍ Yes. Continue to Section F.
❍ No. Skip to Section G.

Section F. Other insurance information

- If there is more than one policy, attach additional paper.
- **If another health insurance plan pays first, send us a copy of their Explanation of Benefits (EOB).**

Other insurance company information			
Company name	Telephone number	Effective date of coverage	
Street address	City	State	Zip code
Policyholder information			
Name of policyholder	Date of birth (mm/dd/yyyy)	Relationship to our subscriber	
Employer or group name, if applicable			
Define the type of coverage. Select one. ❍ Group policy ❍ Individual policy	Above policy covers - select one ❍ Active employee ❍ COBRA coverage ❍ Retiree ❍ Other. Explain: _____		
Policy ID (Social Security Number, Member ID, etc.)	Group number		
Above policy is for - select all that apply ☐ Medical ☐ Dental ☐ Vision ☐ Prescription drug	Above policy covers - select all that apply ☐ Subscriber ☐ Spouse ☐ Dependent children		

Section G. Signature – Print this form then sign it

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature of subscriber or spouse X_____	Printed name Date signed (mm/dd/yyyy)

Questions and Answers to Help You Understand Coordination of Benefits (COB)

What is Coordination of Benefits (COB)?
COB is two or more health care companies working together to share the cost of health care expenses.

Why do we coordinate benefits?
Insurance regulations allow health care companies to coordinate benefits. These regulations allow us to keep your cost of healthcare coverage as low as possible by avoiding payment of more than the total charge of bills submitted. These rules identify one plan as “primary” (the company that pays first) and the other plan as “secondary” (the company that pays second.)

Who do I submit my bill(s) to first?
- If the patient is our Subscriber, submit to us first and the other plan second.
- If the patient is the spouse of our Subscriber, submit to the other plan first and to us second.
- If the patient is a dependent child, submit to the plan of the parent whose birthday falls **earliest in the year**. Example: mother’s birth date is May 5th and father’s birth date is November 9, submit to the **mother’s** plan first.
- If the parents of the patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage according to the divorce decree. If not stated in the divorce decree, submit bill(s) in the following order:
    A. To the plan of the parent with custody;
    B. To the plan of the spouse of the parent with custody;
    C. To the plan of the natural parent without custody; or
    D. To the plan of the spouse of the parent without custody.
- If you have two coverages with us, submit each bill with both Subscriber and Group identification numbers.
- If Medicare is your primary carrier, submit your bill(s) to us with a copy of the Medicare Explanation of Benefits.
- If you are the Subscriber of more than one health care coverage, the coverage which has been effective the longest is primary. Submit your bill(s) to that carrier first.
- Retiree Plans may require any non-retiree coverage to be primary.

How do we coordinate benefits?
- When we receive your bill(s), we will determine which health care company will process your bill(s) first.
- If you submit your bill(s) with a copy of your other health care company’s denial or an Explanation of Benefits, we will use this information to process your bill(s) promptly.
- If we do not receive this information with your bill(s), we contact your other health care company to obtain the information needed to process your bill(s). We always call those companies that coordinate over the telephone. This enables us to process
  your bill(s) promptly.

When do I receive an “Other Coverage Questionnaire”?
- When we have conflicting, incomplete, or outdated information, you will receive a questionnaire.
- When your other coverage cancels, we need new coverage information.

IMPORTANT REMINDERS
- When we request COB information, please return the form by the date indicated to enfdasure prompt processing of your bill(s).
- Always keep your health care providers (doctor, dentist, etc.) updated with your correct health care coverage information.

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທ່ເໝາະສົມແບບບ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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