BlueCross BlueShield Nebraska

Member Name:

COORDINATION OF BENEFITS FORM **Member ID:**

Section 1 – Member Insurance Information

Are you, your spouse or dependent children covered by medical and/or dental coverage other than your Blue Cross and Blue Shield of Nebraska policy?

☐ No, only Blue Cross and Blue Shield of Nebraska (Finish by completing Section 7)	☐ Yes, **other** insurance or TRICARE (Finish by completing Sections 2-5, and 7)	☐ Yes, Medicare (Finish by completing Sections 6 and 7)	☐ Yes, Medicaid or CHAMPUS/VA (Finish by completing Section 7)

Section 2 – Other Insurance/TRICARE Information

Please list all applicable health and/or dental insurance carriers in the space provided. Attach another sheet if needed.

Insurance Company Name or TRICARE Insurance Administrator	Insurance Company or TRICARE Admin Phone	Type of Coverage (circle all that apply)	Type of Enrollment (circle one)	Other Insurance/TRICARE Effective date	TRICARE Status (circle one)
		Medical/Physician Hospital Prescription Drug Dental	Single Family Employee/Spouse Employee/Child		Active Reserves Retiree

Section 3 – Policyholder Information for Other Insurance

Policyholder on the policy indicated in section 2:

Last name

First name

Identification Number (include all letters and numbers):

Policyholder DOB:

Employer name if applicable:

Relationship to the BCBSNE policyholder listed at the top: ☐ Self ☐ Spouse ☐ Dependent ☐ Ex-spouse or legally separated spouse ☐ Other

If relationship is "self" or "spouse," indicate employment status:

☐ Actively working with employer offering other coverage
☐ Not actively working/Long-term disability
☐ Retired from employer providing other coverage
- Retirement date: _______________

☐ On COBRA
- COBRA date: _______________

Continued on next page

Section 4 – Covered Persons

Complete the following information for all persons covered under the other policy (attach a separate sheet if additional space is needed).

	Covered Person First and Last Name	Relationship to the policyholder in Section 3 (i.e., self, spouse, child, step-child, custodial parent)	Date of Birth (mm/dd/yyyy)	Check if covered by Medicare or Medicaid	Check if dependents are covered under court order
A					
B					
C					
D					
E					
F					

Section 5 – Parents that are Divorced, Legally Separated or Never Married

Only complete this section if dependent children are covered under the other policy and the parents are divorced, legally separated or were never married.

If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the court order.	☐ Mother	☐ Father	☐ Joint responsibility	☐ Legal Guardian
If there is no legally binding agreement for health care expense, who has primary custody?	☐ Mother	☐ Father	☐ Joint legal custody	☐ Legal Guardian

Section 6 – Medicare Enrollee Information

Beneficiary Name	Medicare ID	Employment Status	Coverage Type	Effective Date	Medicare Entitlement Reason		
		☐ Employed	☐ Part A		☐ Age	☐Disability	☐ ESRD
		☐ Retired	☐ Part B				
		Date:	☐ Part D				
		☐ Employed	☐ Part A		☐ Age	☐Disability	☐ ESRD
		☐ Retired	☐ Part B				
		Date:	☐ Part D				

Section 7 – BCBSNE Policyholder Signature

____ ______________________________

Signature Date Signed

Daytime phone number: ____________________________

Instructions for Coordination of Benefit Form

Coordination of Benefits (COB) applies when more than one insurance company provides you and/or your family members with health care benefits. COB is applicable to you and all family members that are covered under your Blue Cross and Blue Shield of Nebraska (BCBSNE) health and/or dental plans.

The following instructions can be used to assist you in filling out the attached COB form. **Every Blue Cross and Blue Shield of Nebraska policyholder must complete the COB form annually.**

The COB form can be completed in the following ways:

1. Electronically: Log in to your member account at www.mynebraskablue.com to complete and submit the COB form online. Forms can be found in the Tools and Resources section.
2. Paper: Complete and submit the attached hard copy, which can be mailed or faxed back to us

Mail to: Blue Cross and Blue Shield of Nebraska
PO Box 3248
Omaha NE 68180-0001

Fax to: 402–392-4126

Not yet registered for your online member account?
To sign up for your personalized member account, follow these three easy steps:

1. Visit myNebraskablue.com or download the app, and enter your email address and set up your password
2. Provide the following information:
    a. ID number
    b. Full name
    c. Zip code
    d. Date of birth
    e. Last four numbers of SSN
3. Select three security questions and provide answers

Section 1 – Member Insurance Information:
If you or any of your dependents are not covered under another health or dental plan, answer No and skip to Section 7. Please sign and date and provide a daytime phone number so we can contact you if we have any questions. Your form will need to be returned to us at the address or fax number above.

If you or any of your dependents are covered under another health or dental plan (in addition to your BCBSNE plans), please select Yes to all other answers that apply.

If you answered “Yes, other insurance or TRICARE”, complete Sections 2 – 5, and 7
If you answered “Yes, Medicare”, you will need to compete Sections 6 and 7.
If you answered “Yes, Medicaid or CHAMPUS/VA”, you only need to complete Section 7.

Section 2 – Other Insurance/TRICARE Information:
You only need to complete this section if you answered “Yes, other insurance or TRICARE” in Section 1. Please provide the name and phone number of the other health and/or dental companies that cover you and/or your dependents in addition to BCBSNE. Indicate the type of coverage, type of enrollment and effective date. Please select all that apply to you and your family.

If covered under TRICARE, in addition to the coverage and enrollment type questions, please provide status and effective date. Effective date only needs to be provided for active and retiree status.

If you have coverage with more than two other insurance companies, please attach a sheet including all the information indicated.

Section 3 – Policyholder Information of Other Insurance:
Complete this section if you answered “Yes, other insurance or TRICARE” in Section 1. This information pertains to the additional insurance coverage you or your dependents have with another insurance company (as indicated in Section 2). Not your BCBSNE plan.

Please provide the policyholder’s first and last name, identification number of the other insurance, date of birth, and employer, if applicable. Select the relationship to the BCBSNE policyholder and their employment status.

For example, if your spouse has additional coverage through their employer, your spouse would be the policy holder; their relationship to you (BCBSNE policyholder) would be spouse. In this example, they would mark "Actively working with employer offering other coverage."

Section 4 – Covered Persons
Complete this section if you answered “Yes, other insurance or TRICARE” in Section 1. “Covered persons” refers to all individuals covered under the other plan and your BCBSNE plan. Please attached a second sheet if needed.

Section 5 – Parents that are Divorced, Legally Separated or Never Married
Complete this section if you answered “Yes, other insurance or TRICARE” in Section 1. Only complete this section if dependent children are covered under both your BCBSNE policy and the other policy, and the parents are divorced, legally separated or never married. Please answer the questions provided on the form and include the legal documentation, if applicable, when return the COB form.

Section 6 – Medicare Enrollee Information
Complete this section if you answered “Yes, Medicare” in Section 1. The beneficiary, Medicare ID, coverage type and effective date information can be found your Medicare identification card. Please answer all questions that apply.

Section 7 – BCBSNE Policyholder Signature
Please sign and date and provide a daytime phone number so we can contact you if we have any questions. The primary policyholder or spouse on the BCBSNE policy should sign the form. Your COB form will not be complete unless it is signed.