BlueCross BlueShield Nebraska

Member Name: _____

Member ID: _____

COORDINATION OF BENEFITS FORM

Section 1 – Member Insurance Information

Are you, your spouse or dependent children covered by any other medical and/or dental coverage?

☐ No, only Blue Cross and Blue Shield of Nebraska (Complete Section 7)	☐ Yes, **other** insurance or TRICARE (Complete Sections 2-5 & 7)	☐ Yes, Medicare (Complete Sections 6 & 7)	☐ Yes, Medicaid or CHAMPUS/VA (Complete 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 Number	Type of Coverage (select all that apply)	Type of Enrollment (select one)	Other Insurance/ TRICARE Effective Date (mm/dd/yyyy)	TRICARE Status (select 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 policyholder listed at the top: ☐ Self ☐ Spouse ☐ Dependent ☐ Ex 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 effective date _____

Section 4 - Covered Persons

Complete the following information for all persons covered under the other policy. Attach a separate sheet if 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)	Mark if covered by Medicare or Medicaid	Mark if dependents are covered under court order
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐
5.			☐	☐
6.			☐	☐

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 (mm/dd/yyyy)	Medicare Entitlement Reason
		☐ Employed ☐ Retired Date:_____	☐ Part A ☐ Part B ☐ Part D	_____ _____ _____	☐ Age ☐ Disability ☐ ESRD
		☐ Employed ☐ Retired Date:_____	☐ Part A ☐ Part B ☐ Part D	_____ _____ _____	☐ Age ☐ Disability ☐ ESRD

Section 7 - Policyholder Signature

_____ Signature

_____ Date

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 current health and/or dental plans.

The following instructions can be used to assist you in filling out the attached COB form.

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

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, 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. 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).

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 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 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 BCBS 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 BCBS 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 – BCBS 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 BCBS policy should sign the form. Your COB form will not be complete unless it is signed.