Cerner HealthPlan Services

Coordination of Benefits Questionnaire

We are requesting information to verify if your spouse and/or your dependent(s) have other health insurance coverage. If so, we are required to coordinate benefits with the other carrier.

Please complete the requested information to avoid delay in claims processing. Claims will not be considered for payment without this information.

Information

Name: ______________________________ **Member ID Number:** ___________________
(999999 99999)

1. Do you or any dependents have any other **Group Health or Medicare** coverage?

No _________ Yes _______

If 'NO', please sign, date and return this form.
If 'YES' please complete the information below, sign, date and return the form.

Mail to: Cerner HealthPlan Services, PO Box 165750, Kansas City, MO. 64116-5750
Fax to: Cerner HealthPlan Services (816) 571-6994
Email to: ClientServices@cernerhps.com
Call the Contact Center, toll-free at 1-877-765-1033

Your signature_____________________________________ **Date**:_________________

2. Please list the family member covered by the other **Group** policy and the type of coverage.

___________________________________ __ Medical __Drug __ Medicare
___________________________________ __ Medical __Drug __ Medicare
___________________________________ __ Medical __Drug __ Medicare
___________________________________ __ Medical __Drug __ Medicare

3. Name of other policyholder: ____
Other policy holder's date of birth: ________________ Relationship to you: ___________

4. Employer name if coverage is provided through an employer: _____________________

5. Name of other insurance: ___________________________ Effective Date:___________

6. If there is a divorce or separation, please list who is responsible for the healthcare expenses:
____

If there is not a court decree, who has custody of the children? __________________________

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This Section Pertains to Medicare Coverage Only

7. Is the policyholder actively working? ____ Yes ___ No
   If 'No', last day of active employment _________

8. Family members covered by Medicare, please list name and effective date.
   Name___________________________________ Effective Date________________
   Coverage Type:____
   Name___________________________________ Effective Date________________
   Coverage Type:____

9. Do you or any dependents qualify for Medicare for ESRD? ___Yes___No (If Yes, see ESRD form on back)

ESRD Medicare Questionnaire

ESRD Type of Treatment

The effective date of ESRD Medicare is dependent upon the type of treatment the individual is receiving. Please provide the type of treatment below:

☐ Hemodialysis

☐ Home/Self Dialysis

☐ Transplant

ESRD Effective Date

Coordination of benefits with a group health plan will begin the first month that the individual is eligible for Medicare.
Please provide Medicare effective date: _ _/ _ _/ _ _ _ _
M M D D Y Y Y Y

When an individual has medical coverage through an employer group health plan (EGHP) that plan is the primary payer during the 30-month coordination of benefits (COB) period. Medicare is the secondary payer during this time. At the end of the COB this will reverse, with Medicare becoming primary and the EGHP will be secondary.

Medicare based on ESRD ends with:
The last day of the 36th month after the month the individual receives a kidney.
Transplant or the last day of the 12th month after the month in which an individual stops dialysis, most generally for return of kidney function.

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Your signature_______________________________________ **Date:**______________________

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