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? ____________________________
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:  _/__/____

   MM DD YYYY

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:__________________________

This Section Pertains to Medicare Coverage Only

ESRD Medicare Questionnaire

ESRD Effective Date