COORDINATION OF BENEFITS FORM
Please return form within 20 business days by mail,
call in the information to 757-687-6309, or fax to 757-552-7199

Subscriber's Name: _____ ID#:_____
Group#: _____

Are you, your spouse or dependent children, who are currently enrolled in our plan, also covered by any other medical insurance plan?

_____ NO If "**No**," then no other information is required. **Complete Section 4 and return.**
_____ YES If "**Yes**," **please complete the following sections below**.

SECTION 1. OTHER HEALTH INSURANCE (**Medicare recipients please skip to Section 3**)
Name of Insurance Carrier:_____
Insurance Address:_____
Insurance Phone#:_____
Name of Policy Holder:_____
Policy#/ Contract#:_____
Policy holder's DOB:_____
Effective date of policy:_____
Group name and/or number:_____

List members covered under the other health insurance plan that are covered under our plan:

NAME: (FIRST)	DATE OF BIRTH (MONTH/DAY/YEAR)	RELATION (SPOUSE,CHILD,STEPCHILD)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle the items covered under other insurance policies.
Dental Coverage Vision Coverage Pharmacy Coverage

SECTION 2. CHILDREN WITH PARENTS/GUARDIANS WHO ARE SEPARATED/DIVORCED:

Is there a court order that establishes which parent has medical responsibility for the dependent children?

Yes_____ Parent Name? _____No_____

Does either parent have custody of the dependent children?

Yes_____ Parent Name? _____ No_____

Is there joint legal custody of dependent children? Yes_____ No_____

If Yes, list parents date of birth? Mother: _____ Father _____

SECTION 3. MEDICARE:

Are you, your spouse or dependent children, who are currently enrolled in our plan, also covered by Medicare?

_____ NO If "No," complete section 4 and return form to Optima Health.
_____ YES If "Yes," please complete the information in Section 3 and Section 4.

Subscriber Name:_____ Medicare ID#_____

Part A: (Y/N)_____ Effective Date_____
Part B: (Y/N)_____ Effective Date_____
Part D: (Y/N)_____ Effective Date_____
Retired:(Y/N)_____ Retirement Date_____

Medicare Qualifying Reason:(Select one of the following reasons for Medicare eligibility)

Age (Y/N)_____ (65 years of age or older)

Disability (Y/N)_____ (Under 65). Are you actively working? (Y/N)_____

End Stage Renal Disease (Y/N)_____ If yes, First Date of Dialysis _____

Other please explain:_____

_____

Spouse/Dependent Name:_____ Medicare ID#_____

Part A: (Y/N)_____ Effective Date_____
Part B: (Y/N)_____ Effective Date_____
Part D: (Y/N)_____ Effective Date_____
Retired:(Y/N)_____ Retirement Date_____

Medicare Qualifying Reason:(Select one of the following reasons for Medicare eligibility)

Age (Y/N)_____ (65 years of age or older)

Disability (Y/N)_____ (Under 65). Are you actively working? (Y/N)_____

End Stage Renal Disease (Y/N)_____ If yes, First Date of Dialysis _____

Other please explain:_____

_____

SECTION 4. CERTIFICATION:
I hereby certify that except as indicated above, no services or payments are provided or are recoverable through any other group insurance or service plan.

Subscriber Signature:_____ Date:_____
(HC112.2.LTR)