PREMERA | BLUE CROSS

PO Box 94059
Seattle, WA 98111

Alaska AIRLINES HORIZON AIR

Other Coverage Questionnaire

In order to pay your claims in a timely manner, we need information about other health plan coverage you may have — even if you have none. Please complete and return this form or call Customer Service at **877-AAG-3525** (TTY 800-842-5357) with the requested information. You can find your subscriber information on your health plan ID card.

SUBSCRIBER NAME AND ADDRESS

_____

_____

_____

DATE _____

MEMBER ID # _____

GROUP # _____

GROUP NAME _____

The information requested below will help us coordinate payment of your claim(s) with your other carrier(s). If your spouse or domestic partner is offered coverage through their employer, they must enroll on that plan in order to be eligible as a dependent on your health plan. Please refer to the FAQ following this form.

OTHER INSURANCE INFORMATION

Do you or any family members have any of the following?

1. Coverage with Premera Blue Cross (other than listed above)**?** ☐ **No** ☐ **Yes** If yes, please complete this section.

SUBSCRIBER NAME	DATE OF BIRTH (MM/DD/YYYY)	SUBSCRIBER ID #	GROUP #

2. Medicare coverage? ☐ **No** ☐ **Yes** If yes, please complete this section for each Medicare recipient and include a copy of the Medicare card(s).

SUBSCRIBER NAME		MEDICARE ID #	PART A EFF. DATE	PART B EFF. DATE	PART D EFF. DATE
RETIREMENT DATE	Are you entitled to Medicare due to one of the following? ☐ DISABILITY ☐ KIDNEY FAILURE If checked, please provide the following dates:		DATE OF ENTITLEMENT	DATE OF FIRST DIALYSIS TREATMENT	DATE OF KIDNEY TRANSPLANT
Are you entitled to Medicare for more than one reason? If so, provide detail about your dual entitlement on a separate page.					

3. Other medical or prescription drug coverage? ☐ **No** ☐ **Yes** If yes, please complete the below sections. If another health plan pays first, please provide a copy of your explanation of benefits (EOB). If more than one policy, attach additional page.

POLICY/HEALTH PLAN NAME		PHONE	
ADDRESS	CITY	STATE	ZIP CODE

FORM CONTINUED ON NEXT PAGE

NAME OF POLICYHOLDER (SUBSCRIBER)		DATE OF BIRTH (MM/DD/YYYY)
RELATIONSHIP TO OUR SUBSCRIBER	POLICY ID # (SSN, MEMBER ID, ETC.)	GROUP #
Please check the box for the type of policy/plan: ☐ GROUP PLAN ☐ INDIVIDUAL PLAN ☐ COBRA COVERAGE	Please check the box (or both) for the type of coverage: ☐ MEDICAL ☐ PRESCRIPTION DRUGS	
NAME OF EMPLOYER	Are you retired? ☐ Yes ☐ No	Please check the box for the type of policy/plan: ☐ GROUP PLAN ☐ INDIVIDUAL PLAN ☐ COBRA COVERAGE

4.Do you have dependent children? If parents are divorced or legally separated, the following information is needed to determine which policy/plan will process claims first for dependent children.

CHILD'S NAME FIRST	CHILD'S NAME LAST	NAME OF PERSON WITH CUSTODY	RELATIONSHIP TO CHILD	NAME OF PERSON RESPONSIBLE FOR HEALTH CARE COVERAGE ACCORDING TO DIVORCE DECREE	RELATIONSHIP TO CHILD	**NAME OF OTHER POLICY***

*If this is different from the health plan listed in section 3, please provide all other coverage information (e.g., telephone number, name of policyholder, ID number, group number, etc.) on a separate page.

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGNATURE OF SUBSCRIBER OR SPOUSE

X

Please return completed form any additional pages to:

Premera Blue Cross
PO Box 91059
Seattle, WA
98111-9159

FAQS ON NEXT PAGE

Coordination of Benefits Frequently Asked Questions (FAQ)

What is coordination of benefits (COB)?

COB is two or more health plan carriers working together to share the cost of health care expenses.

Why do we coordinate benefits?

Insurance regulations allow health plan carriers to coordinate benefits. These regulations allow us to keep your cost of health care coverage as low as possible by avoiding payment of more than the total charge of bills submitted. These rules identify one plan as "primary" (the carrier that pays first) and the other plan as "secondary" (the carrier that pays second).

Who do I submit my bill(s) to first?

- If the patient is our subscriber, submit to us first and the other plan second.
- If the patient is the spouse or domestic partner of our subscriber, submit to the other plan first and to us second.
- If the patient is a dependent child, submit to the plan of the parent whose birthday falls earliest in the year. Example: mother's birth date is May 5th and father's birth date is November 9, submit to the mother's plan first.
- If the parents of the dependent patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage according to the divorce decree. If not stated in the divorce decree, submit bill(s) in the following order:
    - To the plan of the parent with custody;
    - To the plan of the spouse of the parent with custody;
    - To the plan of the natural parent without custody; or
    - To the plan of the spouse of the parent without custody.
- If you have two policies with us, submit each bill with both subscriber and group identification numbers.
- If Medicare is your primary carrier, submit your bill(s) to us with a copy of the Medicare explanation of benefits (EOB).
- If you are a subscriber of more than one health plan, the coverage which has been effective the longest is primary. Submit your bill(s) to that carrier first.
- Retiree plans may require any non-retiree coverage to be primary.

How do we coordinate benefits?

When we receive your bill(s), we determine which health plan carrier will process your bill(s) first. If you submit your bill(s) with a copy of your other health plan carrier's denial or an EOB, we will use this information to process your bill(s) promptly. If we do not receive this information with your bill(s), we contact your other health plan carrier to obtain the information needed to process your bill(s). We always call those carriers that coordinate over the telephone. This enables us to process your bill(s) promptly.

When do I receive an "Other Coverage Questionnaire"?

When we have conflicting, incomplete or outdated information, you will receive a questionnaire. When your other health plan coverage cancels, we need new coverage information.

IMPORTANT REMINDERS

When we request COB information, please return the form by the date indicated to assure prompt processing of your bill(s). Always keep your health care providers (doctor, dentist, etc.) updated with your correct health care coverage information.

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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