PREMERA HMO

P.O. Box 91059
Seattle, WA 98111

Other Coverage Questionnaire Enrollment

Customer Service: 844-722-4661
TTY: 711

Dear Subscriber:

We appreciate your assistance in providing information about other health coverage you may have — thank you for your cooperation! Please either review this form and call Customer Service at 1-844-722-4661 with the information or complete the form and mail to the address above.

Subscriber Name and Address

_____

_____

_____

Date _____

Member ID _____

Group Number _____

Group Name _____

If you or your dependents have other health coverage, the information requested below will enable us to coordinate payment of your claim(s) with your other carrier(s). Please refer to the back of this form for answers to the most often asked coordination of benefits questions. If you require assistance in completing this form, please contact your employer or our Customer Service Department.

OTHER INSURANCE INFORMATION

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

1. Coverage with us (other than listed above)? ☐ **No** ☐ **Yes** If Yes, please complete the following line.

SUBSCRIBER NAME	DATE OF BIRTH MONTH DAY YEAR	SUBSCRIBER ID NUMBER	GROUP NUMBER

2. Medicare coverage ☐ **No** ☐ **Yes** If Yes, please complete the following sections. If there is more than one member with Medicare Coverage, use a separate piece of paper. **Please include a copy of your Medicare card(s) for each Medicare recipient.**

NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE		MEDICARE ID NUMBER	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	DATES REQUIRED IF DISABILITY OR KIDNEY FAILURE CHECKED:	DATE OF ENTITLEMENT	FIRST DIALYSIS TREATMENT	KIDNEY TRANSPLANT
Are you entitled to Medicare for more than one reason? If so, give the reasons for your dual entitlement.					

3. Other medical, dental, prescription drug, or vision coverage? ☐ **No** ☐ **Yes**

If Yes, please complete the following sections. If more than one policy, please attach additional paper.

IF ANOTHER HEALTH INSURANCE PLAN PAYS FIRST, SEND US A COPY OF THEIR EXPLANATION OF BENEFITS.

OTHER INSURANCE COMPANY:

COMPANY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER		
EFFECTIVE DATE OF COVERAGE		

NAME OF POLICYHOLDER	DATE OF BIRTH MONTH DAY YEAR
RELATIONSHIP TO OUR SUBSCRIBER	
IS POLICY A GROUP COVERAGE? ☐ NO ☐ YES IS COVERAGE AN INDIVIDUAL POLICY? ☐ NO ☐ YES	IS THIS COBRA COVERAGE? ☐ NO ☐ YES
POLICY ID # (SOCIAL SECURITY #, MEMBER #, ETC.)	
GROUP #	
EMPLOYER: ARE YOU RETIRED? ☐ NO ☐ YES	
ABOVE POLICY IS FOR: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUGS	
ABOVE POLICY COVERS: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT CHILDREN	

(OVER)

4. If parents are divorced or legally separated, the following information is needed to determine which coverage will process claims first for dependent children.

CHILD'S NAME FIRST	LAST	NAME OF PERSON WITH CUSTODY	RELATIONSHIP TO CHILD LISTED	NAME OF PERSON WITH FINANCIAL RESPONSIBILITY FOR HEALTH COVERAGE ACCORDING TO DIVORCE DECREE	RELATIONSHIP TO CHILD	**NAME OF OTHER COVERAGE PROVIDED***

* If this is different from the Other Insurance Company listed in Question Number 3, please list all other coverage information (e.g., telephone number, name of policyholder, ID Number, Group Number, etc.) on a separate sheet.

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

Questions and Answers to Help You Understand Coordination of Benefits (COB)

What is Coordination of Benefits (COB)?

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

Why do we coordinate benefits?

Insurance regulations allow health care companies 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 company that pays first) and the other plan as "secondary" (the company 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 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 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:
  - A. To the plan of the parent with custody;
  - B. To the plan of the spouse of the parent with custody;
  - C. To the plan of the natural parent without custody; or
  - D. To the plan of the spouse of the parent without custody.
- If you have two coverages 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.
- If you are the Subscriber of more than one health care coverage, 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 care company will process your bill(s) first.
- If you submit your bill(s) with a copy of your other health care company's denial or an Explanation of Benefits, 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 care company to obtain the information needed to process your bill(s). We always call those companies 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 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.

PREMERA HMO

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO provides free aids and services to people with disabilities 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 HMO provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-722-4661 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-722-4661（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.