

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
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**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: <input type="checkbox"/> DISABILITY <input type="checkbox"/> 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		

(OVER)

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

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.

## Notice of availability and nondiscrimination 844-722-4661 | 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.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ ដើម្បីជួយចំណាត់ថ្នាក់ដល់សមាសភាពផ្សេងៗ។

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 ሙሳሪዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ 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 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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO 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 Blue Cross HMO 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 Blue Cross HMO 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](mailto: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/online-services/cc/pub/complaintinformation.aspx>.