BlueCross BlueShield of Montana

Coordination of Benefits Questionnaire

BCBSMT POLICYHOLDER NAME	BCBSMT GROUP #	BCBSMT MEMBER ID#

Your Blue Cross and Blue Shield of Montana contract contains a Coordination of Benefits provision. If there is any other insurance, this form is required by BCBSMT in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply. Please return the completed form to Blue Cross and Blue Shield of Montana, PO Box 660255, Dallas, TX 75266-0255.

OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)

Are you or any other member of this BCBSMT policy covered by another medical or dental insurance policy or any other Blue Cross and Blue Shield policy?

NO ☐ IF NO, PLEASE MAKE ANY REVISIONS NECESSARY TO THE INFORMATION IN SECTION A, SIGN, DATE AND RETURN THIS QUESTIONNAIRE TO US, INDICATING **"NO OTHER INSURANCE."**	**YES** ☐ IF YES, PLEASE MAKE ANY REVISIONS NECESSARY TO THE INFORMATION IN SECTION A AND COMPLETE ALL THE FIELDS BELOW THAT PERTAIN TO THE MEMBER(S) **THAT HAS OTHER COVERAGE.**

SECTION A

NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX ☐M ☐F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX ☐M ☐F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX ☐M ☐F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX ☐M ☐F	SSN (OPTIONAL)
SIGNATURE				DATE

SECTION B (IF THIS DOES NOT APPLY, SKIP TO SECTION C)

CHECK THOSE THAT APPLY ☐ **OTHER HEALTH INSURANCE** ☐ **OTHER DENTAL INSURANCE**

WHAT TYPE OF POLICY IS THIS? ☐ **GROUP** ☐ **INDIVIDUAL POLICY** ☐ **STUDENT POLICY** ☐ **MEDICARE SUPPLEMENTAL**

OTHER INSURANCE CARRIER'S NAME
(IF MORE THAN ONE, LIST ON SEPARATE PAGE)

ADDRESS	CITY	STATE	ZIP

DEPENDENT(S) LISTED ON THE OTHER INSURANCE	EFFECTIVE OR CANCEL DATE, IF DIFFERENT FROM POLICYHOLDER (MM/DD/YYYY)
NAME	DATE
NAME	DATE
NAME	DATE
NAME	DATE
NAME	DATE

OTHER INSURANCE POLICYHOLDER'S NAME	
POLICYHOLDER'S DATE OF BIRTH (MM/DD/YYYY)	IDENTIFICATION #:
EFFECTIVE DATE OF OTHER INSURANCE	IF CANCELLED, CANCELLATION DATE

IS THE POLICYHOLDER: ☐ **ACTIVELY WORKING FOR THE GROUP** ☐ **INACTIVE**

☐ **RETIRED, RETIREMENT DATE:** ☐ **ON COBRA, WHICH BEGAN ON DATE:**

POLICYHOLDER'S EMPLOYER			
EMPLOYERS ADDRESS	CITY	STATE	ZIP

SECTION C — MEDICARE INFORMATION (IF THIS DOES NOT APPLY, SKIP TO SECTION D)

DOES THE POLICYHOLDER AND/OR DEPENDENT(S) HAVE MEDICARE?	☐ **YES**	☐ **NO**
NAME OF PERSON(S) WITH MEDICARE	MEDICARE NUMBER, INCLUDING ALPHA CHARACTER(S)	
EFFECTIVE DATE OF MEDICARE PART A (MM/DD/YYYY)	EFFECTIVE DATE OF MEDICARE PART B (MM/DD/YYYY)	
EFFECTIVE DATE OF MEDICARE PART C (MM/DD/YYYY)	EFFECTIVE DATE OF MEDICARE PART D (MM/DD/YYYY)	

MEDICARE ENTITLEMENT	☐ **AGE**	☐ **DISABILITY***	☐ **END STAGE RENAL DISEASE (ESRD)***

***IF THE REASON IS FOR DISABILITY OR ESRD, PLEASE PROVIDE THE FOLLOWING:**

1ST DATE OF DISABILITY	**WAS ESRD STARTED AS SELF DIALYSIS OR HOME DIALYSIS?** ☐ **YES** ☐ **NO**
1ST DATE OF DIALYSIS FOR ESRD	**HAS A TRANSPLANT BEEN PERFORMED?** ☐ **YES** ☐ **NO**
1ST DATE OF DISABILITY	**WAS ESRD STARTED AS SELF DIALYSIS OR HOME DIALYSIS?** ☐ **YES** ☐ **NO**
WAS ESRD STARTED IN A FACILITY? ☐ **YES** ☐ **NO**	IF YES, PLEASE PROVIDE THE DATE OF THE TRANSPLANT

IN ADDITION, PLEASE PROVIDE A COPY OF THE MEDICARE CARD

SECTION D — COURT ORDER INFORMATION

IS THERE A COURT ORDER SPECIFYING A PERSON(S) WHO MUST MAINTAIN HEALTH COVERAGE FOR ANY OF YOUR DEPENDENT(S)? ☐ **YES** ☐ **NO**

LIST THE NAME(S) OF THE DEPENDENT(S) TO WHOM THE COURT ORDER APPLIES:

IF YES, WHO IS THE PERSON(S) LISTED TO MAINTAIN HEALTH COVERAGE?

WHAT IS THE RELATION TO THE CHILD(REN)?

WHO HAS CUSTODY OF THE CHILD(REN) MORE THAN 50% OF THE TIME?

DOCUMENTATION OF THE COURT ORDER MAY BE REQUESTED FROM YOUR BLUE CROSS AND BLUE SHIELD PLAN.