



A UnitedHealthcare Company

# Coordination of Benefits Form

Please submit this form with all supporting documentation to Oxford's Coordination of Benefits Department at:

**Mailing Address:** P.O. Box 7071, Bridgeport, CT 06601-9630 • 1-800-767-3840

## SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Oxford Subscriber Name: \_\_\_\_\_ Oxford ID Number: \_\_\_\_\_

### Employment Information (Please check the appropriate boxes)

Actively at Work:  Yes  No Total number of employees at company is:  1-19  20-99  100+

Retired:  Yes  No Date of Retirement: \_\_\_/\_\_\_/\_\_\_ Spouse's Social Security Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Spouse's Current Employer/Company Name: \_\_\_\_\_

Spouse's Employer Address/Phone Number: \_\_\_\_\_

## COVERAGE INFORMATION

### Please note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part A1, then sign and date the form.
- No other coverage, please complete Part A2, then sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, then sign and date the form.
- Medicare coverage, please complete Part C, then sign and date the form.

## PART A

### 1. Other Coverage (list each separately)

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

Policy Effective Dates: Start \_\_\_/\_\_\_/\_\_\_ End \_\_\_/\_\_\_/\_\_\_ Covered Dependents: \_\_\_\_\_

#### Coverage Type:

(Check applicable)  Hospital  Major Medical  Prescription  Dental  Retiree  COBRA  Other

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

Policy Effective Dates: Start \_\_\_/\_\_\_/\_\_\_ End \_\_\_/\_\_\_/\_\_\_ Covered Dependents: \_\_\_\_\_

#### Coverage Type:

(Check applicable)  Hospital  Major Medical  Prescription  Dental  Retiree  COBRA  Other

If the other coverage is no longer in effect, you must enclose documentation from the former carrier indicating the date the policy was terminated.

### 2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason:  Not married

Benefits not offered  Unemployed  Self-employed  Waived, as of: \_\_\_/\_\_\_/\_\_\_

Part-time employee (not eligible for benefits)  Waiting period, eligible for coverage on: \_\_\_/\_\_\_/\_\_\_

Other, please explain: \_\_\_\_\_

Please turn over

**PART B**

**Please complete this section if you are divorced, legally separated, or a single parent, and you have dependent children covered under this plan.**

1. Does the other biological parent of your dependent children provide health benefits?  Yes  No  
 Name of other biological parent: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_

**If yes, please provide the following information:**

Name of other health plan: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Subscriber's SS #: \_\_\_\_\_  
 Which children are covered? \_\_\_\_\_

2. Are you divorced or legally separated?  Yes  No Date of divorce/separation: \_\_\_/\_\_\_/\_\_\_  
 Are you a single parent?  Yes  No

**If divorced, check one of the following:**

- Divorce decree stipulates other parent must provide health benefits
- Divorce decree stipulates joint custody
- Divorce decree does not stipulate any special provisions
- Other, please explain: \_\_\_\_\_

**\*A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.**

**PART C**

**You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.**

Name of Member eligible for Medicare: \_\_\_\_\_

Name of Member eligible for Medicare: \_\_\_\_\_

Effective Dates of Medicare:  
 Part A: \_\_\_/\_\_\_/\_\_\_ Part B: \_\_\_/\_\_\_/\_\_\_

Effective Dates of Medicare:  
 Part A: \_\_\_/\_\_\_/\_\_\_ Part B: \_\_\_/\_\_\_/\_\_\_

Reason for Medicare coverage  
 (please check one):  
 Age 65 or older  
 End Stage Renal Disease (ESRD)

Reason for Medicare coverage  
 (please check one):  
 Age 65 or older  
 End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: \_\_\_/\_\_\_/\_\_\_  
 Disability, due to: \_\_\_\_\_

Date Dialysis Treatment Began: \_\_\_/\_\_\_/\_\_\_  
 Disability, due to: \_\_\_\_\_

**SUBSCRIBER SIGNATURE**

I certify that the above information is correct and understand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Print Your Name: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Oxford ID Number: \_\_\_\_\_