Coordination of Benefits Questionnaire

Your Summary Plan Description document for the Kern Legacy Health Plan Employee Medical Benefit Plan contains a Coordination of Benefits (COB) provision. COB is a process regulated by law that determines financial responsibility of payment of covered expenses when an individual is covered by two or more group health plans. We depend upon your help in order for us to process your claims correctly and appreciate your prompt reply in completing the below questionnaire.

Policyholder Name: _____

Member ID Number: _____ Group # (If applicable) _____

Section **A** **Other Insurance** *If this does not apply, check "No" and skip to Section B*

Is the patient or any other member of this insurance policy covered by another medical or dental insurance policy, including Medicare?

___NO If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

___YES If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark 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 _____//_____

Address _____

City _____ State _____ Zip _____ Phone _____

Dependent(s) listed on the other insurance _____

Other Insurance Policyholder's Name _____

Policyholder's Date of Birth _____

ID Number_____

Effective Date of Other Insurance _____ If Cancelled, Cancellation Date _____

Is the policy holder: ☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: _____

☐ On COBRA, which began: _____

Policyholder's Employer _____

Address _____

City _____ State _____ Zip _____ Phone _____

Section **B** Medicare Information *If this does not apply, check "No" and skip to Section C*

Do 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: _____ Effective date of Medicare Part B: _____

Medicare Entitlement: ☐ Yes Disability* ☐ Yes End Stage Renal Disease (ESRD)*

If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:_____

1st Date of Dialysis for ESRD:_____

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis? ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of the transplant: _____

Section **C** Court Order Information

Who has custody of the child(ren) more than 50% of the time _____

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ **Yes** ☐ **No**

If yes, who is the person(s) listed to maintain health coverage and their relation to the child(ren)?

_____

List the name(s) of the dependent(s) that this applies to

_____

_____

_____

(Documentation of the court order may be requested from your Plan)

Section D Names of Dependent(s) on HealthEdge Policy

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Subscriber Signature: _____ **Date:** _____

Daytime phone number where you can be reached for questions: (_____) _____

NOTE: *If any of the above information in the questionnaire changes, please call Member Services to obtain a new form.*

Please return the completed signed form by email, fax or standard mail.

Mail: HealthEdge Administrators
PO Box 11210
Bakersfield, CA 93389-1210

Fax: 661-616-4889

Member Services: 855-308-KLHP (5547)
(Select Option 1 for Member Services and option 1 for Claims)

Email: eligibility@healthedgeinc.com
(Please use secure or encrypted Email to Protect Private Health Information-PHI)