COORDINATION OF BENEFITS FORM

PATIENT NAME: _____

MEMBER ID#: _____

DATE OF SERVICE: _____

Dear Patient:
Your insurance company contract has a Coordination of Benefits Provision. Coordination of Benefits (COB) prevents duplicate payment for the same covered health expense; thus helping to control the cost of coverage. ,

This provision applies when a member is covered under more than one group health plan. Your insurance company needs you to confirm whether you (or a family member) have other medical coverage. -

FAILURE TO DISCLOSE ANY OTHER INSURANCE COVERAGE FOR THIS PATIENT MAY RESULT IN DISMISSAL PROCEEDINGS FROM THIS PRACTICE.. NON-DISCLOSURE OF ADDITIONAL COVERAGE IS CONSIDERED **FRAUD** BY THE INSURANCE COMPANY INDUSTRY, AND YOU MAY BE DISMISSED FROM THE PRACTICE.

Is your spouse or any dependent employed?_____ If yes by whom?_____

Do you or your family members have other medical coverage? YES_____NO_____

If NO, the form is completed, please sign below and date the form. If YES, please continue.

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Is this coverage through employment? YES:_____ NO:_____

Insured Name/SSN#: _____

Employer Name/Phone#: _____

Policy Name/Phone#: _____

When did coverage begin? _____

Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____