OTHER HEALTH COVERAGE QUESTIONNAIRE

BLUECHOICE HEALTHPLAN
Blue Cross BlueShield of South Carolina
Your Partner in Good Health™

Managed Care Organization ★★★★ NCQA Accreditation EXCELLENT

Your contract contains a Coordination of Benefits (COB) provision to ensure correct benefits are provided on claims for members covered by more than one health insurance plan. We need information about possible other insurance coverage, including Medicare, before we can process your claims. Please complete this form and return it to the address listed on the bottom of this form. If you or a family member has Medicare or other coverage that has already provided benefits for these services, please attach the Explanation of Benefits notice to this form. If you have any questions or need help to fill out this form, please call 1-800-868-2528. Thank you for your cooperation.

I.D. Card #: _____ Name on ID Card: _____
First Name Last Name

Your Spouse's Name:	Spouse's Social Security Number:	Spouse's Date of Birth:
Is your Spouse employed? Yes _____ No _____	If your spouse is employed, please list the employer's name and telephone number:	
Are you actively at work? Yes _____ No _____	If you are actively at work, your work schedule is: FULL-TIME _____ PART-TIME _____	Date that you began work with current employer:

Are you retired? Yes _____ No _____ If "yes," your retirement date:

Do you have group health insurance under continuation of coverage (COBRA)? Yes _____ No _____ If "Yes," please give the date that continuation under COBRA began:

Do you, your spouse, or dependent child(ren) have Medicare coverage? Yes _____ No _____

If "Yes," please list the names, dates of birth, Medicare ID Numbers, and effective dates of hospital and medical coverage for all family members who have Medicare because:

They are age 65 or older:	They are disabled:	They have permanent kidney failure:

Are any family members disabled but not yet covered by Medicare? Yes _____ No _____
If "Yes," please list their names, dates of birth, and dates that disability began:

Do any family members have permanent kidney failure, but are not yet covered by Medicare? Yes _____ No _____
If "Yes," please list their names, dates of birth, and dates that kidney dialysis began:

Are you, your spouse, or dependent child(ren) covered by a group health plan other than this one? Yes _____ No _____
If "Yes," please furnish the following information:

Name of Policyholder with other coverage:	Policyholder's relationship to you:	Name of other insurance company:

Check each type of service covered by the other plan: ☐ HOSPITAL ☐ PHYSICIAN/MEDICAL ☐ PRESCRIPTION DRUGS ☐ DENTAL CARE

Names of all family members covered by the other plan:

If divorced or separated, is there a court decree establishing financial responsibility for the health care expenses of the child(ren)? Yes_____ No_____

If "Yes," name of responsible person: _____

If "No," who has custody of the child(ren)? _____

CERTIFICATION: I certify that the information I have provided is complete, true, and correctly recorded to the best of my knowledge.

Your Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO BLUECHOICE HEALTHPLAN, MAIL CODE AX-420, P.O. BOX 6170, COLUMBIA, SC 29260-6170 OR FAX TO 803-714-6443.