Coordination of Benefits (COB) Verification Questionnaire

Please complete this form to help us coordinate your health insurance benefits. This questionnaire is designed for printing and manual completion or direct typing. Do not leave any sections blank; write "N/A" if a section does not apply to you.

Section 1: Primary Policyholder Information

Subscriber Full Name:	
Member ID / Policy Number:	
Group Number:	
Date of Birth (MM/DD/YYYY):	
Phone Number:	

Section 2: Other Insurance Coverage

Are you or any family members covered by another health insurance plan, including Medicare?

Other Coverage Active? (Yes / No): ______

If "Yes", please complete the details below regarding the other insurance policy:

Other Insurance Company Name:	
Other Insurance Phone Number:	
Policy ID / Certificate Number:	
Group Number:	
Policyholder Full Name:	
Policyholder Date of Birth (MM/DD/YYYY):	
Relationship to Primary Subscriber:	e.g., Self, Spouse, Child
Policy Effective Date (MM/DD/YYYY):	
Type of Coverage:	e.g., Medical, Dental, Vision

Section 3: Medicare Coverage (If Applicable)

Medicare Number (MBI/HICN):	
Medicare Part A Effective Date:	
Medicare Part B Effective Date:	
Reason for Medicare Entitlement:	Age, Disability, or End-Stage Renal Disease

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Section 4: Certification and Signature

I certify that the information provided on this form is true, accurate, and complete to the best of my knowledge.

Printed Name of Member:	
Date Signed (MM/DD/YYYY):	
Signature (If printed):	Sign on line when printed