Core Management Resources Group

Other Health/Dental/Financial Assistance Questionnaire

Your policy contains a Coordination of Benefits (COB) provision. To ensure we provide correct benefits for members with more than one health/dental coverage plan, information about possible other health/dental coverage including Medicare is required to process your claims correctly. Please completed and return this form within thirty (30) days.

Full Name: _____ ID Number: _____

Street Address: _____ Employer: _____

City, State ZIP: _____ Date: _____

1. Do you or any dependents have other health, dental, Medicaid or Medicare coverage? ◯ No ◯ Yes
   If you answered yes, please proceed to question #2.

   Your Signature:_____ Date:_____

2. *Please list the family members covered by any other policy and the type of coverage you have.*

   Name: _____ Relationship: _____ ☐ *Medical* ☐ *D*ental ☐ Medicaid/Medicare

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3. Name of Other Policyholder:_____

   Other Policyholder's Date of Birth:_____ Relationship to You: _____

4. What <u>financial assistance programs</u> are you <u>or any dependents</u> participating in (for example: prescription co-pay assistance, patient advocacy organizations, financial support resources, or specialized care support foundation (s)?

_____

5. If Coverage is Provided Through an Employer, Employer's Name: _____

6. Name of Other Insurance Company:_____ Effective Date:_____

   Address:_____ Telephone No:_____

   If policy is /has terminated, termination date:_____ ID Number:_____

   Note: Please submit a Certificate of Creditable Coverage which notes the termination date.

7. If there is a divorce or separation, list the person responsible for the healthcare expenses: _____

   If there is a copy of a divorce decree, please forward a copy to us. If there is not a court decree, who has custody of the child(?) _____

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