

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	☐ Dental	☐ Medicaid/Medicare
Name: _____	Relationship: _____	☐ Medical	☐ Dental	☐ Medicaid/Medicare
Name: _____	Relationship: _____	☐ Medical	☐ Dental	☐ Medicaid/Medicare
Name: _____	Relationship: _____	☐ Medical	☐ Dental	☐ Medicaid/Medicare

3. Name of Other Policyholder: _____

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

4. What financial assistance programs are you or any dependents 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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