ACCOUNT # _____

COORDINATION OF BENEFIT FORM

Dear Patient:

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company.

Please complete Sections 1, 3 and 4 of this form. **(Please complete Section 2 only if auto accident.)**
In order to expedite your claim process, the following information must be completed.

Patient ID#_____ Group Name and #_____

Patient's Name:_____ Subscriber's Name:_____

SECTION 1 ☐ Incident report copied

Name of Specialist you are seeing:_____
Date of Visit:_____ Referred by:_____
Is the reason for your visit due to an injury caused by an accident? ☐ No ☐ Yes
Date of Accident/injury:_____ ☐ Auto ☐ Work ☐ School ☐ Home ☐ Other_____
How and when did accident occur?_____
_____

*If no injury, please explain the problem:*_____
_____ When did problem start?_____

Was a third party responsible for your injury? ☐ Yes ☐ No If yes, please provide the following:
Name and address of individual or company:_____
_____
Name and address of attorney representing third party:_____

SECTION 2 ☐ Insurance Card copied **(Information to be completed only if auto accident:)**
Were you in your own vehicle? ☐ Yes ☐ No If NO, car owner's name:_____
Were you the driver? ☐ Yes ☐ No Passenger? ☐ Yes ☐ No Other_____
Were you wearing a seat belt? ☐ Yes ☐ No
Name and address of Insurance Company:_____
Claim#_____
Claim's Adjuster:_____ Phone:_____

SECTION 3 ☐ Insurance Card copied
Full name of your spouse:_____ SS #_____
Spouse's Employer:_____ Spouse's Birth date:_____
Is your spouse covered by any Health insurance company? ☐ Yes ☐ No
If so, please provide name of Insurance Carrier:_____

SECTION 4 ☐ Insurance Card copied
Is your problem covered by any other insurance? ☐ yes ☐ No

To the best of my knowledge the statements above are accurate and complete and unanswered questions indicate they do not apply. My signature authorizes_____ Insurance to receive any and all information concerning claims filed by me or on my behalf to another insurance carrier.

DATE:_____

SIGNATURE:_____ PRINTED NAME:_____

WITNESS SIGNATURE:_____ PRINTED NAME:_____