



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: _____