MAGELLAN HEALTH SERVICES
Getting Better All the Time

Date:_____

Member Name:_____

Member SSN/ID #:_____

Member Address:_____

Member DOB:_____

Your behavioral health plan, administered by Magellan Health Services, contains a coordination of benefits (COB) provision which applies to situations where there may be overlapping coverage. To ensure accurate processing of claims without COB delays, please complete the following information within 10 business days and return it to us at the following address:

Magellan Behavioral Health
P.O. Box 1009
Maryland Heights, MO 63043

COORDINATION OF BENEFITS (COB) FORM

SECTION I

1. Do you have other coverage through another group health plan? Yes _____ No_____
2. If so, are you covered as an active employee or a retiree?_____.
3. Please indicate the name of the carrier and effective date: Carrier:_____.
   Effective date:_____
4. If you are married, is your spouse employed? Yes _____ No_____
5. If yes, name of spouse's employer:_____ Spouse's date of birth_____.
6. Does your spouse have group coverage through his/her employer? Yes___ No___ *If yes, complete section 11.*
7. If so, is your spouse covered as an active employee or a retiree? _____

SECTION II

1. Name of spouse's insurance carrier:_____, Phone#:_____.
2. Group/Policy Number:_____, Insured ID/SSN:_____.
3. Effective date:_____. Termination date:_____. Family__. or individual____. coverage?

SECTION III

If you have children, and you are legally separated or divorced, please complete the following:

1. Is there a court decree stating financial responsibility? Yes _____ No _____
2. Who has responsibility?_____.
3. Who has custody of the children?_____.
4. Does anyone other that the natural parents (step-parents) carry insurance on the dependent(s)? Yes___No___
   If yes, please provide Name of Policyholder:_____.
   Insurance Carrier:_____ID/SSN:_____ Phone#:_____.

SECTION IV

1. Are you, your spouse, or your dependents covered under Medicare? Yes ___ No___ If yes, please complete the following:
2. Name and date of birth of person(s) covered:_____.
3. Medicare ID#:_____ Is Medicare coverage due to disability caused by end stage renal disease? Yes ___ No___
4. Date of onset:_____ Date eligible for Medicare:_____.
5. Do you have part A? Yes ___ No ___ . Do you have part B? Yes ___ No___.

I certify that the above information is correct. Employee Signature_____Date_____.