

Coordination of Benefits for Other Insurance Coverage

If you have other insurance in addition to your **UnitedHealthcare** coverage, we will need your other insurance information. By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.

* indicates required fields, as applicable

PATIENT » *Name of Patient: _____ *Date of Birth: _____

INSURED » *Name of Insured: _____ *Phone #: _____

*Relationship to Patient: Self Spouse Parent Other _____

Group or Claim #: _____ Subscriber / Member #: _____

*Does the Patient have other insurance or Medicare Coverage?

- YES » Continue with form
 NO » Go to **Signature** section

OTHER INSURANCE CARRIER:

* Name of the Subscriber for the Other Insurance policy: _____

* Name of the Employer: _____

* Name of Other Insurance Carrier: _____

Insurance Carrier Claim address: _____

Insurance Carrier phone number: _____

*Policy Number: _____ *Group Number: _____

*Beginning date of Coverage: _____ *End date of Coverage (if applicable): _____

Other insurance covers? Self Spouse Child Other _____

PHARMACY

Pharmacy name: _____ Pharmacy phone number: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): _____

Relationship of other insurance member to child: Parent Stepparent Legal Guardian Other _____

Child resides with: Parent Stepparent Legal Guardian Other _____

Person(s) with legal custody: Parent Stepparent Legal Guardian Other _____

Is there a court decree that has assigned primary responsibility for health care coverage? Yes No

Relationship of party with decreed responsibility: Parent Stepparent Legal Guardian Other _____

Name of responsible party: _____

Address: _____

Name and date of birth of both parents	Mother's name: Date of Birth:	Father's name: Date of birth:
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MEDICARE:

*Name of Individual Covered by Medicare: _____

*Medicare ID#: _____

Date of Birth: _____ Date of Retirement (if applicable): _____

*Medicare Part A effective date (if applicable): _____

*Medicare Part B effective date (if applicable): _____

*Medicare Part D Prescription Drug Coverage effective date (if applicable): _____

*Entitlement Reason: Age

Disability Date disability began: _____

End Stage Renal Disease First date of dialysis: _____

Kidney transplant date: _____

SIGNATURE:

*Insured or Patient Name (print): _____

*Signature of Insured or Patient: _____ *Date: _____