Mail completed form to:

Blue Cross Blue Shield of North Dakota
4510 13th Ave S, Fargo, ND 58121

Coordination of Benefits Questionnaire

Thank you for being a Blue Cross Blue Shield of North Dakota (BCBSND) member.

As part of your BCBSND health insurance coverage, your plan includes a Coordination of Benefits service. This service applies when you have more than one health or dental insurance. To aid in this process, we need some additional information about your health care coverage.

Within seven days, please complete, sign and return this form to BCBSND in the enclosed envelope. A prompt response will ensure accurate processing of future claims. If you have any questions or prefer to provide this information over the phone, please call the number on the back of your Insurance card.

BCBSND Policy Holder Name _____

BCBSND Benefit Plan Number _____

BCBSND Claim Number _____

Were you or any other member of this BCBSND policy covered by another health insurance policy on _____ or within the past year?
(Date of Service)

☐ Yes Please complete Section(s) A, B (if applicable), and D.
☐ No Please complete Section D.

Were you or any other member of this BCBSND policy covered by another dental insurance policy on _____ or within the past year?
(Date of Service)

☐ Yes Please complete Section(s) A, B (if applicable), and D.
☐ No Please complete Section D.

Do you and/or a member of your family have Medicare coverage?

☐ Yes Please complete Sections C and D.
☐ No Please complete Section D.

SECTION A

OTHER INSURANCE COMPANY'S INFORMATION

(Please attach additional page(s) if you have more than one other insurance policy)

Name of Other Insurance Company		Other Insurance Phone Number	
Other Insurance Company's Address, Street, City, Zip			
Type of Insurance: ☐ Group Policy ☐ Life Policy ☐ Excess Policy ☐ Other _____ ☐ Medicare Supplemental Policy			
Type of Policy Coverage: ☐ Single ☐ Policyholder & Child Only ☐ Children Only ☐ Family ☐ Policyholder & Spouse ☐ Spouse Only			
Name of Policy Holder	Date of Birth	Policyholder's Sex: ☐ Male ☐ Female	
Other Insurance Policy Number	Group Number	Policyholder's Employer	Policy Effective Date
Employment Status (Complete if other insurance policy is provided by an employer): ☐ Active ☐ Retired ☐ Unemployed ☐ Self Employed ☐ Continuation of Coverage (COBRA)			
Employees in Group: ☐ Less than 20 ☐ 20 or more ☐ 100 or more ☐ Unknown			
Persons Covered by Other Insurance	Date of Birth	Relationship	Social Security Number
1.			
2.			
3.			
4.			

Please notify your healthcare provider of any changes to your health benefits to ensure claims are filed to the correct insurance carrier.

Patient Name: _____ Benefit Plan Number: _____

SECTION B

COMPLETE THIS SECTION IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER

Please provide BCBSND with a complete, signed copy of the divorce decree or other court document for your affected dependent child(ren), to ensure benefits are coordinated correctly. Providing facts needed to determine the order of benefits and pay claims properly, including a copy of this legal document is a requirement outlined in your Benefit Plan with BCBSND. If there is no document, you must verify this in writing for each dependent child. This information is required for proper claims payment. Failure to provide the requested document(s) will delay claims processing. Complete the information below for each dependent child.

Child's Name	Custodial Parent(s) Name and Month/Day of Birth	Non-Custodial Parent(s) Name and Month/Day of Birth	Joint Custody Yes/No	Person with whom child lives and phone number
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

SECTION C

MEDICARE COVERAGE

Subscriber's Name	Gender: ☐ Male ☐ Female	Medicare Claim Number
Part A Effective Date _____ Term Date _____	Part B Effective Date _____ Term Date _____	
Reason(s) for Medicare: ☐ Age ☐ Disability ☐ End Stage Renal Disability	Date of First Dialysis Treatment:	Location of Treatment: ☐ In Home ☐ Dialysis Facility
Spouse or Dependent	Gender: ☐ Male ☐ Female	Medicare Claim Number
Part A Effective Date _____ Term Date _____	Part B Effective Date _____ Term Date _____	
Reason(s) for Medicare: ☐ Age ☐ Disability ☐ End Stage Renal Disability	Date of First Dialysis Treatment:	Location of Treatment: ☐ In Home ☐ Dialysis Facility

SECTION D
INFORMATION CERTIFICATION
This section must be completed and signed by the subscriber.

To the best of my knowledge the information provided is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to BCBSND all information concerning claims filed by me or on my behalf.

Subscriber's Signature	Date of Birth	Work Phone Number	Home Phone Number	Today's Date

If your address has changed, please call the number on the back of your insurance card to update