QualChoice® HEALTH INSURANCE

Coordination of Benefits Questionnaire

Your QualChoice contract may contain a Coordination of Benefits (COB) provision. We depend on your help to process your claims correctly. We appreciate your prompt and accurate reply. Please return the questionnaire within 30 calendar days.

Section I: Subscriber Information

Name of QualChoice Subscriber *(Last, First, Middle Initial)*	
QualChoice ID No.	Contact Phone No.

Are you, or any member of your family who are covered by QualChoice, also covered by another group health plan or Medicare?

☐ **Yes.** If Yes, complete Section II (if another group health plan), or Section III (if Medicare).

☐ **No.** If No, please sign below and return this form to us.

Section II: Other Group Health Plan. *Please attach a copy of the insurance ID card.*

Group Health Plan Name		Policy or Group No.	
Address	City	State	Zip
Name of Policyholder	Date of Birth (MM/DD/YYYY)	Effective Date of Coverage	If cancelled, give date.

List all family members (include yourself) also covered by this group health plan, their relationship to you (the Subscriber), and the parent responsible for coverage. If there is a court order for dependent coverage, please check below. Send a copy of the order.

Name	Relationship	Parent Responsible for Coverage	Is there a court order?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section III. Medicare Information. *Please attach a copy of the Medicare ID card.*

Are you actively/presently employed? ☐ Yes ☐ No

List all family members (include yourself) also covered by Medicare.

Name	Medicare ID No.	Medicare eligibility due to:			Effective Date		
		Age 65+	*Disability*	*Renal Disease*	Part A	Part B	Part D
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			

Section IV: Authorized Signature

I understand and agree that any omissions or false information knowingly given by myself and/or my eligible dependents on this form may cancel coverage for me and/or my covered dependents.

Subscriber's Signature	Date (MM/DD/YYYY)

Section V: Instructions

You can return this form to us by fax or mail. Be sure to include all requested items.

QualChoice
Attn: Claims Department
P.O. Box 25610 • Little Rock, AR 72221
Fax: 501.228.0135

IMPORTANT

If you or a family member have other insurance coverage, please send a copy of your insurance ID card. If there is a court order for dependent medical coverage, please send a copy of the court order. Failure to respond within 30 calendar days will result in claims being pended/denied until this questionnaire is returned.