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Are you or a covered dependent also covered by another health plan?

COORDINATION OF BENEFITS INFORMATION FORM

“Coordination of Benefits” is the process used when a person is covered by more than one health plan. To ensure prompt payment of your health care claims, the information below must be completed for each person covered by your health plan. Please return this form within 14 days in the enclosed postage paid envelope, even if you or your covered persons do not have other health plan coverage. Please use a separate sheet of paper if more room is needed.

1. Are you or any covered persons on your health plan covered by another group or individual health plan, other than Medicare?

YES _____ NO _____

If YES, please complete the following. If NO, please continue to #2.

Name of Person With Other Health Plan: _____

Date of Birth: _____ SS#: _____ Employer: _____

Name of Dependents Covered by Other Health Plan:

Name & Address of Other Health Plan: _____

Contract or Plan # and Effective Date: _____

Please check all that apply, one minimum:

Type of Contract: Single _____ Two-person _____ Family _____ Other Coverage _____

Please check all that apply, one minimum:

Type of Coverage: Hospital ___ Medical ___ Surgical ___ Pharmacy ___ Vision ___ Dental ___

Additional Benefits/Other Coverage: _____

2. Are you or any covered persons on your health plan covered by or eligible for Medicare (e.g. 65 or older, disabled)?

YES _____ NO _____

If YES, please complete the following. If NO, please continue to #3.

Name of person with Medicare coverage: _____

Medicare ID#: _____ Effective Date(s) Part A: _____ Effective Date(s) Part B: _____

The reason for Medicare coverage:
Please check all that apply, one minimum.

_____ Age 65 or older & actively employed, or _____ Age 65 or older & retired, on long-term disability or a survivor

_____ End Stage Renal Disease
Date when dialysis began: _____

_____ Disability
Date when eligible for Social Security: _____

If YES, employer name: _____

If NO, retirement date (or date no longer employed): _____

3. Have you or any covered person on your plan had an accident, injury, or illness that is covered by No-Fault (auto), Workers compensation, or other liability insurance?

YES _____ NO _____

If YES, please complete the following. If NO, please sign and date at the bottom and return.

Name of person(s) covered as described above: _____

Date of Birth: _____ SS#: _____ Employer: _____

Type of Other Insurance: Workers Comp _____ No-Fault _____ Other _____

Name & Address of Other Insurance Carrier: _____

Date of Injury/Illness/Accident: _____ Claim/Case#: _____

Describe Injury/Illness/Accident: _____

If work related, was the covered person's employer notified of this injury/illness/accident?

YES _____ NO _____

I certify that all of the information requested has been completed fully and accurately.

Subscriber's Signature

Date

By signing above, I certify and affirm, under pain and penalty of perjury, that the information provided in this form is true. I also understand that if I provide materially false information on or omit material information from this form, and I or a covered person subsequently submit a benefit claim impacted by such information, the claim may be considered a fraudulent claim and if so, I and my covered persons will be immediately ineligible for coverage.