COX HEALTHPLANS
CoxHealth

THINKING HEALTH FORWARD

COORDINATION OF BENEFITS INFORMATION FORM
PLEASE REVIEW AND RESPOND IMMEDIATELY

Please Print	
Date (Required):	
Full Name (Required):	
Address (Required):	
City, State Zip (Required):	

Your Cox HealthPlans coverage requires that we coordinate benefits with other health coverage that you or your covered family members may currently have or have had in the recent past. To ensure that we provide accurate claim benefit payment, we need updated information on any other medical/health insurance any member may currently have or have had within the last 12 months. Once we receive this information, any claims that are awaiting payment in our system will be promptly processed according to your plan benefits.

Please respond to the following two questions within 15 days from the date of this letter. All claim(s) will remain pended until this information is received.

For your convenience, this completed form may be mailed to us in the envelope provided. Information may also be taken verbally from the Contractholder listed above by calling our Member Service Department at (417) 269-2900 or (800) 205-7665.

1. Within the last 12 months other than your current Cox HealthPlans policy, have you or any of your enrolled family members had any other group health plan, dental plan, Medicare or Medicaid coverage?

☐ NO -Please proceed to Question #2.

☐ Yes -Please answer the following:

Other Dental or Health Insurance--please enclose a copy of the front & back of your other insurance card.

Name of policyholder:	Date of Birth (mo/day/yr)	Group or Policy Number:	Effective Date:	Term Date:

Please list below the contract holder and any other dependent covered by other health/medical policy:

Name:	Date of Birth	Relationship	Effective Date:	Term Date:

If Employer provided coverage, please provide Employer's name, address, and phone number with area code:

(Please continue on next page)

Insurance Company providing other coverage. Name, address, phone number with area code:

Policy #	**Member ID#**	**Coverage start date:**

Coverages (mark all that apply) ☐ **Medical** ☐ **Prescription** ☐ **Group** ☐ **COBRA/Continuation** ☐ **VA Benefits** ☐ **Retirement** ☐ **Individual** ☐ **Dental**

Medicare - Please enclose a copy of the front and back of your Medicare card

Is any member of your policy eligible for Medicare? ☐ No ☐ Yes If yes, please complete below.
Is the card holder of Cox HealthPlans policy actively employed? ☐ No ☐ Yes If yes, please complete below.

Name:	Part A	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:
Medicare:	Part B	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:
Name:	Part A	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:
Medicare:	Part B	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:
Name:	Part A	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:
Medicare:	Part B	☐ No ☐ Yes	Effective Date:	Reason for Medicare eligibility:

2. Do you have any dependents covered by Cox HealthPlans where coverage has been assigned by court order or divorce decree?

☐ No -Please sign, date and return this form in the envelope provided.
☐ Yes -Please answer the following:

Dependent Information

In relation to your dependents whom are covered by Cox HealthPlans where coverage has been assigned by court order or divorce decree, have you previously provided Cox HealthPlans with a current court order or divorce decree?

☐ YES -Please sign, date and return this form in the envelope provided.
☐ NO -Please answer the following:

Court Order Information

Please submit a copy of the follow: the first page of the court order showing the respondent and petitioner, sections regarding health insurance, and the page with the court official signature and date signed.

Who has physical custody?	**Who is responsible for coverage?**
1.	
2.	
3.	

I certify that the statements contained in this document are true and correct to the best of my knowledge.

Signature_____ **Date** _____

Thank you for your assistance.

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