Coordination of Benefits (COB)

DELTA HEALTH SYSTEMS
Administration Services

Claim # _____
Health Care ID # _____
Patient Name: _____
Relationship: _____

Name: _____
Address: _____
City: _____ ST: _____ Zip: _____

Date: ____/_____/_____

In order to process your claims (Medical, Dental or Vision) administered by Delta Health Systems, the plan requires a completed Coordination of Benefits (COB) form every year. The form provides information about whether you, your spouse or your dependents are covered under more than one health care plan so that we can process your claims correctly. As soon as possible, please return:

- this completed form, **AND**
- if applicable, a copy of the front and back of the insurance card from your other carrier. Note: If you or your spouse have Medicare coverage please submit copies of your Medicare cards.

IMPORTANT: Failure to complete any of the required fields below may result in delay or denial of related claims.

Section 1: Other Coverage

Do you or any of your dependents have any other health insurance coverage? Yes ☐ No ☐

If yes, please complete Section 2 and sign Section 3. **If no,** please sign Section 3. To ensure there is no delay in processing your claims, please return this form to the address listed at the bottom of this letter at your earliest convenience.

Section 2: Information Necessary to Coordinate Benefits

Other Health Insurance Company Information

Name of Carrier: _____ Telephone Number: _____
Address: _____
Policy or ID Number: _____ Effective Date of Coverage: _____
Coverage Termination Date: _____
Policyholder's Name: _____ Date of Birth (MM/DD/YY): _____
Name of Employer: _____ Active: ☐ / Retiree: ☐

Type of Coverage

☐ **Medical** Please Select Type: ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Other_____
☐ **Medicare** ☐ **Medicaid/Medi-Cal** ☐ **Dental** ☐ **Vision** ☐ **Prescription Drug**

Covered Dependents

Name(s)	Relationship to Participant	Date of Birth (MM/DD/YY)	If there is a court order, who is responsible for providing health coverage?	Custodial Parent's Name

Section 3: Verification

I hereby verify that the above information is true, complete and accurate to the best of my knowledge.

Signature _____ Date _____ Telephone _____