Coordination of Benefits for Insurance Coverage Form

Primary Insurance Company Name: _____

NOTE: If you have other insurance in addition to your primary coverage, we will need your other insurance information to send to your primary insurance company. By coordinating benefits among all insurance carriers, you will receive the maximum benefits available. (*Required Fields)

PATIENT

*Name of Patient: _____ *Date of Birth: _____

INSURED

*Name of Insured: _____ *Phone #: _____

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Group or Claim #: _____

***Does the Patient have other insurance or Medicare Coverage?**

☐ YES » Continue with form ☐ NO » Go to *Signature section*

OTHER INSURANCE CARRIER

*Name of the Subscriber for the Other Insurance policy: _____

*Name of the Employer: _____

*Name of Other Insurance Carrier: _____

*Insurance Carrier Claim address: _____ Carrier Phone #: _____

*Policy #: _____ *Group #: _____

Beginning date of Coverage: _____ *End date of Coverage (if applicable): _____

*Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

PHARMACY

Pharmacy name: _____ Pharmacy phone #: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): _____

Relationship of other insurance member to child: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

(Continue on Page 2)

Fraud Compliance Notice: *"Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20." Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

*"**California Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." Per California Insurance Code Section 1871.2 If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com*

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Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes* ☐ No

- Relationship of party with decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____
- Name of responsible party: _____
- Address: _____

Name and date of birth of both parents	
◦ Mother's name: _____	◦ Father's name: _____
◦ Date of Birth: _____	◦ Date of Birth: _____

MEDICARE

*Name of Individual Covered by Medicare: _____

*Medicare ID#: _____

Date of Birth: _____ Date of Retirement (if applicable): _____

*Medicare Part A effective date (if applicable): _____

*Medicare Part B effective date (if applicable): _____

*Medicare Part D Prescription Drug Coverage effective date (if applicable): _____

*Entitlement Reason:

- ☐ Age
- ☐ Disability Date disability began: _____
- ☐ End Stage Renal Disease: _____
- ☐ First date of dialysis: _____
- ☐ Kidney transplant date: _____

SIGNATURE: _____

*Insured or Patient Name (print): _____

*Signature of Insured or Patient: _____

*Date: _____

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