

COORDINATION OF BENEFITS FORM

Dear Patient:

In many cases insurance carriers will coordinate medical benefits with other insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. Please take a moment to complete the following information so that we may expedite your claim process.

Patient Name: _____ Subscriber's Name: _____
Patient ID#: _____ Group Name and #: _____

SECTION 1- COMPLETE THIS SECTION- IF SECTIONS 2 AND 3 ARE NOT APPLICABLE PROCEED TO SECTION 4.

Date of visit: _____ Referred by: _____

What are we seeing you for today? _____

Is the reason for your visit due to an injury caused by an accident? Yes No

Date of Accident/Injury: _____ Related to: Auto Work School Other

How, when and where did the accident occur? _____

If no, please explain the problem: When did the problem start? _____

Was a third party responsible for your injury? Yes No

If yes, please provide the following: Name and address of individual or company

Are you currently working? Yes No If no, last date that you worked? _____

Do you have an attorney? Yes No

If yes, name and phone number: _____

SECTION 2- COMPLETE ONLY IF YOUR SPOUSE IS THE INSURED FOR THE PRIMARY INSURANCE

Full name of your spouse _____ SS# _____

Spouse's employer _____ DOB: _____

Is your spouse covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

SECTION 3- COMPLETE ONLY FOR CHILDREN UNDER 18 AND/OR FULL TIME STUDENTS

Full name of father _____ SS# _____

Father's DOB: _____ Father's employer: _____

Is your father covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

Full name of mother _____ SS# _____

Mother's DOB: _____ Mother's employer: _____

Is your mother covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

SECTION 4

Is your problem covered by any other insurance? Yes No

To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes my insurance to receive any and all information concerning claims filed by me or on my behalf to another insurance carrier.

Patient or Designated Representative Signature

Printed Name

Date