# Coordination of Benefits Form

1. Do you or another family member have other health coverage? If yes, please complete all fields, sign and date.

| | | |
|---|---|---|
| Name of Subscriber | Address | |
| Date of birth | Preferred Administrators Member ID | Patient relationship to subscriber |
| Name of employer group | Effective date of coverage | o Full Time<br>o Part Time |

1. Type of other coverage

☐ Other insurance ☐ Retiree ☐ Medicaid ☐ CHIP

| | | |
|---|---|---|
| Other health plan name | | Effective date of coverage |
| Other health plan address | o Full Time<br>o Part Time | |
| Other health plan phone number | Other health plan member ID number | Is the subscriber:<br>☐ Active ☐ Retired ☐ On COBRA |
| Patient relationship to subscriber | | Date retired |

2. If dependent is under insurance, please provide dependent information.

| | |
|---|---|
| Name | Address |
| Date of birth | ID number (if not the subscriber) |
| Father's name and date of birth | Mother's name and date of birth |

3. If separated or divorced, please provide the following:

Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical care expenses?
☐ Yes ☐ No If yes, specify who: _____

| | | |
|---|---|---|
| Who has custody of the dependent child(ren)? | Who do the child(ren) live with? | How many months of the year? |

4. Do you and/or another family member have Medicare?
If yes, provide the following for each family member with Medicare.

| | | |
|---|---|---|
| Name of Medicare beneficiary | | ☐ Medicare A ☐ Medicare B ☐ Both |
| Medicare member ID | Entitlement reason<br>☐ Age ☐ Disability ☐ End stage renal disease | Effective date |
| If entitled due to end stage renal disease, please provide: | | |
| The date of first dialysis | ☐ Home dialysis<br>☐ Dialysis in facility/dialysis center | Date of transplant, if applicable |

You can return this form to us by mail:

Preferred Administrators (Third Party Department)
1145 Westmoreland Drive
El Paso, TX 79925
Phone number"915-532-3778

| | |
|---|---|
| Print Name of the person completing the form | |
| Signature | Date |

NOTE: Please provide us with copies of your other insurance medical/pharmacy cards. Please don't return this form without a valid signature and date.