COB questionnaire

Priority Health

This coordination of benefits (COB) questionnaire helps make sure your claims are processed accurately if you and/or your dependent(s) have another health plan.

1. Priority Health plan policyholder information

First name	Last name	M.I.
Date of birth _____/_____/_____	Priority Health ID number	

2. Dependent(s) and court order information

Do you have any dependent(s) on your Priority Health plan?

☐ Yes *(complete section 2a.)* ☐ No

Is there a court order requiring someone to maintain health coverage for your dependent(s)?

☐ Yes *(complete section 2b.)* ☐ No

2a. Dependent(s) details

Dependent 1

First name	Last name	M.I.
Date of birth _____/_____/_____	Relationship to policyholder	

Dependent 2

First name	Last name	M.I.
Date of birth _____/_____/_____	Relationship to policyholder	

Dependent 3

First name	Last name	M.I.
Date of birth _____/_____/_____	Relationship to policyholder	

2b. Court order details *(please attach any supporting documentation)*

Who does the court order apply to? *(mark all that apply)*

☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3

Who is listed to maintain health coverage?	What is their relationship to the dependent(s)?

Who has custody of the dependent(s) more than 50% of the time?

3. Other coverage information

Do you or your dependent(s) on your Priority Health plan have coverage with another health plan or a different Priority Health plan, excluding Original Medicare (Part A and/or Part B)?

☐ Yes *(complete section 3a.)* ☐ No

3a. Other coverage details

Health plan name	Policyholder's name

What type of health plan? *(choose one)*

☐ Individual ☐ Employer Group ☐ Medicaid ☐ Medicare Advantage ☐ Medigap

If 'Employer Group', what is the policyholder's status with their employer?

☐ Actively working for the employer ☐ Retired ☐ On COBRA

If 'Retired', what is the retirement date? ____/____/____

If 'On COBRA', when did coverage begin? ____/____/____

What type of coverage? *(mark all that apply)*

☐ Medical ☐ Vision ☐ Dental ☐ Prescription Drug

Who is covered under this health plan? *(mark all that apply)*

☐ Policyholder [ID Number: _____] ☐ Dependent 1 [ID Number: _____]

☐ Dependent 2 [ID Number: _____] ☐ Dependent 3 [ID Number: _____]

Effective date	Cancellation date *(if applicable)*
____/____/____	____/____/____

4. Original Medicare information

Do you or your dependent(s) on your Priority Health plan have coverage with Original Medicare (Part A and/or Part B)?

☐ Yes *(complete section 4a.)* ☐ No

4a. Original Medicare details

Who is covered under Original Medicare (Part A and/or Part B)? *(choose one)*

☐ Policyholder ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3

ID number: _____

Medicare Part A effective date *(if applicable)*: ____/____/____

Medicare Part B effective date *(if applicable)*: ____/____/____

Reason for coverage: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

If 'Disability', what is the effective date? ____/____/____

If 'ESRD', what is the date of first dialysis? ____/____/____

If 'ESRD', where was dialysis conducted? ☐ Facility ☐ Home

If 'ESRD', was a transplant performed? ☐ Yes ☐ No

If 'Yes', what was the date of the transplant? ____/____/____

5. Veterans Administration (VA) information

If you have VA Health Care due to a VA qualified disability, please contact Customer Service by calling the phone number listed on the back of your member ID card.

6. Acknowledgement

Priority Health plan policyholder signature	Today's date
	____/____/____

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم: 711).