



This form must be completed to notify Health Advantage of Medicare or other health insurance coverage for Coordination of Benefits (COB). If you or any member of your family has other health insurance coverage that has not been submitted to Health Advantage, or have a change in other health insurance information, please complete this form and mail to:

Attention: Claims COB Department, Health Advantage P.O. Box 8069, Little Rock, AR 72203-8069

Please check reason(s) for form submission:

Add other insurance     Change in other insurance     Termination of other insurance

Subscriber Name \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Group or Company Name \_\_\_\_\_ Group Number \_\_\_\_\_

## SECTION A – MEDICARE COVERAGE

If you or your spouse have Medicare coverage, Please complete the following:

Policyholder/Subscriber Coverage (yourself)	Spouse Coverage
Social Security ID Number _____	Spouse Name _____
Medicare Identification # _____	Social Security ID Number _____
Date of Birth (MM/DD/YY) _____	Medicare Identification # _____
Coverage type(s) _____	Date of Birth (MM/DD/YY) _____
Hospital Part A: Effective date _____	Coverage type(s) _____
Medical Part B: Effective date _____	Hospital Part A: Effective date _____
<input type="checkbox"/> Active <input type="checkbox"/> Retired (date): _____	Medical Part B: Effective date _____
Reason for Medicare: _____	<input type="checkbox"/> Active <input type="checkbox"/> Retired (date): _____
<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	Reason for Medicare: _____
<input type="checkbox"/> ESRD (End Stage Renal Disease)	<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
Date Qualified for Medicare: _____	Date Qualified for Medicare: _____

## SECTION B – OTHER HEALTH INSURANCE

Please complete this section if you, your spouse or other dependents will have other health coverage in addition to Health Advantage coverage. (Use additional paper if necessary)

First Name	Last Name	Relationship	Coverage effective date	Reside in same household
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Policyholder Name \_\_\_\_\_ Member # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier Address \_\_\_\_\_

For dependent(s) listed above, are you responsible for providing Primary Health Coverage:  Yes  No  
If you are not responsible, provide name of responsible party \_\_\_\_\_

**NOTE:** Please complete SECTION C for dependent children of divorced or separated parents.

**SECTION C – DEPENDENT CHILDREN OF SEPARATED OR DIVORCED PARENTS**

Please complete this section for any dependent child(ren) listed in SECTION B when parents are divorced or legally separated, or have some other legal reason for providing coverage. (Use additional paper if necessary)

Name of child(ren) 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Parents are:  Legally Separated  Divorced

If parents are divorced or legally separated, parents have:  Joint Custody  
 One Parent with Custody

Parent with Custody: Name \_\_\_\_\_  Remarried  Not Remarried

No  Yes. Is there a legally binding agreement stating which parent has responsibility for the child's health care expenses? If Yes, which parent: \_\_\_\_\_. (Attach copy of agreement)

**SECTION D – TERMINATION OF OTHER HEALTH INSURANCE**

Please complete this section if the other health insurance or Medicare coverage has been replaced by another health plan or has been terminated for you, your spouse or other dependent(s).

First Name	Last Name	Relationship	Coverage TERMINATION date

Policyholder Name \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

**SECTION E – SIGNATURE**

I understand that the information provided on this form is true, complete and correctly recorded and will be used by Health Advantage for coordination of benefits and adjudication of claims. My signature authorizes coordination of benefits under my health plan with other insurance plans that are subject to coordination of benefits and for recovery of funds from another party found to be responsible for claims. If the information provided on this form changes, I agree to notify Health Advantage.

Subscriber Signature \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Date \_\_\_\_\_