Coordination of Benefits for Other Insurance Coverage

If you have other insurance in addition to your **UnitedHealthcare** coverage, we will need your other insurance information. By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.

* indicates required fields, as applicable

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

INSURED » *Name of Insured: _____ *Phone #: _____

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

Group or Claim #: _____ Subscriber / Member #: _____

***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: _____
Insurance Carrier phone number: _____
*Policy Number: _____ *Group Number: _____

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

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

PHARMACY

Pharmacy name: _____ Pharmacy phone number: _____

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_____

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: Date of Birth:	Father's name: 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: _____