Many insurance carriers have a Coordination of Benefits provision which is used to determine if there may be overlapping insurance benefits. By having this form on file, we can help expedite the payment of your claims. Failure to complete this form may result in claim denial and charges reverting to your responsibility.

Coordination of Benefits (COB) Form

Section I

1. Do you have coverage through another group health plan? _____ Yes _____ No

2. If so, are you covered as an active employee or retiree? ___ Active ___ Retiree

3. Please indicate the name of the carrier and effective date: Carrier: _____
   Effective Date: _____ Phone Number: _____

4. If you are married, is your spouse employed? ____ Yes ____ No

5. If yes, name of spouse's employer: _____
   Spouse's date of birth: _____

5. Does your spouse have group coverage through his/her employer? __ Yes __ No

Section II

1. Name of spouse's insurance carrier: _____
   Insurance phone number: _____

2. Group/Policy number: _____ Insured ID/SSN# _____

3. Effective date: _____ Termination date: _____
   Family: _____ or individual coverage? _____

I certify that the above information is correct.

Employee Signature _____ Date _____

Patient Name _____ Date of Birth _____
Account Number _____ ID# _____