Patient Name:

Date of Birth:

Coordination of Benefits

(Primary) INSURANCE PLAN: _____

POLICY HOLDER NAME: _____

MEMBER ID #: _____

GROUP #: _____

Your insurance policy may contain a Coordination of Benefits (COB) provision. This form confirms that your child or any other member of this insurance policy does not have another medical insurance policy. If you have any questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card.

☐ My child is covered by only ONE insurance listed above. This coverage is through (check one):

☐ Mother ☐ Father ☐ Guardian/Third Party

☐ In addition to the insurance company listed above, MY CHILD IS ALSO COVERED BY:

Name of Other Health Insurance Company	Name of Policy Holder/Guardian
Health Insurance Policy/ID Number	Policy Holder Relationship to Patient/Guarantor
Group Number	Policy Holder/Guarantor Date of Birth
Employer (if applicable)	

Is this condition related to ☐ Personal injury ☐ Personal illness

LIST NAME(S) OF SIBLING(S) AND POLICY ID NUMBERS (IF APPLICABLE):

Name	Member No.	Date of Birth	Gender
		_____/_____/_____	
		_____/_____/_____	
		_____/_____/_____	
		_____/_____/_____	
		_____/_____/_____	

Print Name _____ Signature _____ Date _____

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