OXFORD HEALTH PLANS®

A UnitedHealthcare Company

Coordination of Benefits Form

Please submit this form with all supporting documentation to Oxford's Coordination of Benefits Department at:
Mailing Address: P.O. Box 7071, Bridgeport, CT 06601-9630 • 1-800-767-3840

SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Oxford Subscriber Name: ______________________ Oxford ID Number: ______________________

Subscriber Employment Information (Please check the appropriate boxes)

Actively at Work: ❑ Yes ❑ No Total number of employees at company is: ❑ 1-19 ❑ 20-99 ❑ 100+

Retired: ❑ Yes ❑ No Date of Retirement: __/__/__

Spouse's Employment Information

Spouse's Name: ______________________ Spouse's Date of Birth: __/__/__

Spouse's Current Employer/Company Name: ______________________

Spouse's Social Security Number: ______________________

Actively at Work: ❑ Yes ❑ No Retired: ❑Yes ❑ No Date of Retirement: __/__/__

COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part A1, then sign and date the form.
- No other coverage, please complete Part A2, then sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, then sign and date the form.
- Medicare coverage, please complete Part C, then sign and date the form.

PART A

1. Other Coverage (list each separately)

Carrier Name: ______________________ Carrier Address: ______________________

Policy ID: ______________ Group ID: ______________ Telephone #: ______________

Subscriber's Name: ______________________ Subscriber's SS #: ______________________

Rx BIN: ______________ Rx PCN: ______________ Rx Group: ______________

Policy Effective Dates: Start __/__/__ End __/__/__ ❑ Single ❑ Subscriber & Spouse ❑ Subscriber & Dependents ❑ Family

Coverage Type:
(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ COBRA ❑ Other

Carrier Name: ______________________ Carrier Address: ______________________

Policy ID: ______________ Group ID: ______________ Telephone #: ______________

Subscriber's Name: ______________________ Subscriber's SS #: ______________________

Rx BIN: ______________ Rx PCN: ______________ Rx Group: ______________

Policy Effective Dates: Start __/__/__ End __/__/__ ❑ Single ❑ Subscriber & Spouse ❑ Subscriber & Dependents ❑ Family

Coverage Type:
(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ COBRA ❑ Other

If the other coverage is no longer in effect, you must enclose documentation from the former carrier indicating the date the policy was terminated.

2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason: ❑ Not married

❑ Benefits not offered ❑ Unemployed ❑ Self-employed ❑ Waived, as of: __/__/__

❑ Part-time employee (not eligible for benefits) ❑ Waiting period, eligible for coverage on: __/__/__

❑ Other, please explain: ______________________

Please turn over

COVERAGE INFORMATION (Continued) Please Print

PART B

Please complete this section if you are divorced, legally separated, or a single parent, and you have dependent children covered under this plan.

1. Does the other biological parent of your dependent children provide health benefits? ❑ Yes ❑ No

   Name of other biological parent: ______________________ Birth date: ___/___/___

   If yes, please provide the following information:

   Name of other health plan: ______________________

   Policy #: ______________________

   Subscriber's SS #: ______________________

   Which children are covered? ______________________

2. With which parent does the child primarily reside? ______________________

   If divorced, check one of the following:

   ❑ Divorce decree stipulates other parent must provide health benefits*

   ❑ Divorce decree stipulates joint custody*

   ❑ Divorce decree does not stipulate any special provisions*

   ❑ Other, please explain: ______________________

***A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.**

PART C

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of Member eligible for Medicare:

____

Effective Dates of Medicare:

Part A: ___/___/___ Part B: ___/___/___ Part D: ___/___/___

Reason for Medicare coverage
(please check one):

❑ Age 65 or older

❑ Disability, due to: ______________________

❑ End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: ___/___/___

Name of Member eligible for Medicare:

____

Effective Dates of Medicare:

Part A: ___/___/___ Part B: ___/___/___ Part D: ___/___/___

Reason for Medicare coverage
(please check one):

❑ Age 65 or older

❑ Disability, due to: ______________________

❑ End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: ___/___/___

SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Print Your Name: ______________________

Signature: ______________________ Date: ______________________

Oxford ID Number: ______________________