Coordination of Benefits Questionnaire

Member Instructions: This form is being sent to you because a claim has been received for you or your dependent(s) that indicates there is possible coverage through another health plan. In order to determine which plan is the primary carrier, the attached form MUST be completed and returned to Verdegard Administrators, LLC. Please make sure you complete the entire form and include a copy of the other insurance I.D. card(s) for each carrier if applicable.

Dependent Children of divorced or separated parents please clearly indicate which parent has custody of the dependent child so coordination of benefits can be determined. Please include a copy of the divorce decree if possible.

If you or your dependent(s) are no longer covered under another insurance plan you MUST submit a Creditable Coverage Letter from the prior insurance carrier to Verdegard Administrators, LLC.

Please note that all claims submitted will be denied until a completed Coordination of Benefits (COB) survey is received by Verdegard. The COB survey is necessary to determine whether you have any other insurance coverage that may be primary to the coverage being claimed. Until we receive a completed COB survey, we will not be able to process your claim. We apologize for any inconvenience this may cause and encourage you to complete the survey as soon as possible to ensure timely processing of your claim.

Please submit a separate form for each Other Insurance Carrier.

Section 1: Family Members Covered Under Verdegard Policy (Please use reverse side if additional space is needed)

Full Name	Verdegard Member ID number	Date of Birth	Is This Member Covered Under Other Insurance Carrier Specified Below?
Employee:			☐ Yes ☐ No
Spouse:			☐ Yes ☐ No
Child 1:			☐ Yes ☐ No
Child 2:			☐ Yes ☐ No
Child 3:			☐ Yes ☐ No
Child 4:			☐ Yes ☐ No

Section 2: Other Insurance Carrier

Name of Other Insurance:		Phone Number:
Address:		
Full Name of Policy Holder:		
Is this coverage for Medicaid? ☐ Yes ☐ No		Policy Holder Date of Birth:
Policy Number:	Group Name or Number:	Effective Date:

Check what is covered under this policy:

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Include a copy of the front and back of Other Insurance Carrier ID card. If this coverage is no longer in effect, you must submit a Creditable Coverage Letter from this carrier.

Section 3: Is This Coverage for Medicare?

Check if it is coverage for Part A, Part B, or both:	☐ Part A	☐ Part B ☐ Both	
Do you carry Medicare due to a disability?	☐ Yes	☐ No	If yes, please explain:
Do you carry Medicare due to end stage renal disease?	☐ Yes	☐ No	If yes, please explain:

The information provided above will only be used to coordinate benefits.

Section 4: Member Signature

Signature **Date**

Please note that failure to complete and return this form could result in delay or termination of benefits.

Please mail, fax, or email completed form to:

Verdegard Administrators, LLC
P.O. Box 22009
Tempe, AZ 85285-2009
Toll-free fax: 800-814-3854
Fax: 480-800-5838
Email: memberforms@verdegard.com