

# COORDINATION OF BENEFITS



MercyCare subscriber name: \_\_\_\_\_

MercyCare member number: \_\_\_\_\_

Employer group number and name: \_\_\_\_\_

Dear subscriber,

To ensure proper and timely payment of your claims, please provide the following information and return in the enclosed postage paid envelope within 15 days. Should you have any questions regarding this, or if your information should change, please call our customer service department at (800) 895-2421. Thank you for your cooperation in this important process.

1. Are you married? No \_\_\_ Yes \_\_\_ Date of birth: \_\_\_\_\_

*\*If yes, please answer questions 2 through 5. If no, please skip to questions 6 through 7.*

2. Is your spouse currently employed? No \_\_\_ Yes \_\_\_ Date of Birth: \_\_\_\_\_

*\*If yes, please provide the following:*

Employer name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

3. Does your spouse have insurance through his or her employer? No \_\_\_ Yes \_\_\_

*\*If yes, please provide the following:*

Insurance co. name: \_\_\_\_\_

Policy/subscriber number: \_\_\_\_\_

Phone: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

4. If you answered yes to question # 3, please advise if your spouse's insurance plan includes prescription coverage. No \_\_\_ Yes \_\_\_

*\*If yes, please provide the following information:*

Plan name: \_\_\_\_\_

Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

5. Please list all members covered by the above plan(s):

\_\_\_\_\_  
\_\_\_\_\_

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6. Are you or any of your dependents covered by Medicare? No \_\_\_\_\_ Yes \_\_\_\_\_

*\*If yes, please fill in the information below.*

Name: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policy/subscriber number: \_\_\_\_\_

Medicare Part A effective date \_\_\_\_\_

Medicare Part B effective date \_\_\_\_\_

Medicare Part D effective date \_\_\_\_\_ Drug plan name \_\_\_\_\_

Medicare claim number: \_\_\_\_\_

Name: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policy/subscriber number: \_\_\_\_\_

Medicare Part A effective date \_\_\_\_\_

Medicare Part B effective date \_\_\_\_\_

Medicare Part D effective date \_\_\_\_\_ Drug plan name \_\_\_\_\_

Medicare claim number: \_\_\_\_\_

7. Are you or any of your dependents covered through another policy?

(Please include coverage dependents may have under a separated/divorce parent) No \_\_\_\_ Yes \_\_\_\_

*\*If yes, please provide the following:*

Insurance co. name: \_\_\_\_\_

Policy/subscriber name: \_\_\_\_\_

Insurance company name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

**If divorced, attach a copy of the court order.**

Other coverage also includes any state aid program, such as BadgerCare Plus.