BlueCross BlueShield of Florida
Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

Member Name:
Address:
City, State, Zip:
Phone #:
Contract #:

Dear Insured:

Your Blue Cross Blue Shield of Florida (BCBSF)/Health Options, Inc. (HOI) contract contains a coordination of benefits provision, which applies when you have more than one health insurance. There are specific laws that mandate the order of payment responsibility for covered services when an individual is covered by Medicare and an Employer Group Health Plan(s). BCBSF/ HOI is required to identify situations where Medicare may have paid benefits in error because an employer group plan should have been the primary payor. BCBSF/HOI is required to report this information to the Health Care Finance Administration (HCFA) on a periodic basis.

Please provide the following information, so we can ensure that our records accurately reflect your health care coverage information. **Complete, sign, and return the questionnaire within 30 days. A prompt response will ensure accurate processing of future claims. You should mail the completed form to the address indicated above. Thank you.**

1. Do you and/or a member of your family have other health insurance in addition to BCBSF/HOI? ____ Yes ____No
   If yes, please complete Section(s) A, B (if applicable), and D.
   If no, please complete Section D on the reverse side.

2. Do you and/or a member of your family have Medicare coverage? ____ Yes ____No
   If yes, please complete Sections C and D.
   If no, please complete Section D on the reverse side.

SECTION A: OTHER INSURANCE COMPANY INFORMATION
(Please attach additional page(s) if you have more than one other insurance policy.)

Name of Other Health Insurance Company	**Type of Insurance:** ( ) Group Policy ( ) Life Policy ( ) Excess Policy ( ) Other_____ ( ) Medicare Supplemental Policy		
Other Insurance Address, Street, City, Zip			
Type of Policy Coverage: ( ) Single ( ) Employee & Child Only ( ) Children Only ( ) Family ( ) Employee & Spouse ( ) Spouse Only			
Name of Policy Holder	**Date of Birth**	**Policyholder's Sex:** ( ) Female ( ) Male	
Other Insurance Policy #	**Group No.**	**Policyholder's Employer**	**Policy Effective Date** _____/_____/_____
Employment Status: ( ) Active ( ) Retired ( ) Unemployed ( ) Continuation of Coverage (COBRA) ( ) Self Employed		**Other Insurance Phone No.** **( )**	
Employees in Group: ( ) Less than 20 ( ) 20 or more ( ) 100 or more ( ) Unknown			

Persons Covered by Other Insurance	**Date of Birth**	**Relationship**	**Social Security No.**
1.			
2.			
3.			
4.			

SECTION B:

COMPLETE THIS SECTION IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER:

Does a court decree state who has financial responsibility for providing health coverage for any dependent also covered by BCBSF/HOI?

( ) NO ( ) YES, the court decree specifies that _____has responsibility.

Name(s)/Relationship(s)

Child's Name	Custodial Parent(s) Name and Month/Day of Birth	Non Custodial Parent(s) Name and Month/Day of Birth	Joint Custody Yes/No	Person with whom child lives

Please provide a copy of the insurance card or insurance information for each policy that covers the dependents listed above if not already provided in Section A.

MEDICARE COVERAGE **SECTION C:**

Subscriber's Name	Sex	Medicare HIC Number	Effective Date Term Date
	( ) Male ( ) Female		Part A_____ _____ Part B_____ _____
Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability		**Date of First Dialysis Treatment:** _____	**Location of Treatment:** ( ) In Home ( ) Dialysis Facility

Spouse or Dependent	Sex	Medicare HIC Number	Effective Date Term Date
	( ) Male ( ) Female		Part A_____ _____ Part B_____ _____
Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability		**Date of First Dialysis Treatment:** _____	**Location of Treatment:** ( ) In Home ( ) Dialysis Facility

SECTION D:

This section must be completed and signed by the subscriber.

Spouse's Name (if applicable)	**Date of Birth**	**Spouse's Social Security Number**

1. Is your spouse employed and eligible for coverage through his / her employer? ( ) Yes ( ) No	2. If yes, did your spouse elect not to have coverage through their employer's group insurance? ( ) Yes ( ) No

To the best of my knowledge the information provided is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to BCBSF/HOI all information concerning claims filed by me or on my behalf.

Subscriber's Signature	Date of Birth	Work Phone No.	Home Phone No.	Today's Date