Blue Cross Blue Shield of Rhode Island

December 19, 2007

Dear Physician/Provider,

Incomplete or missing coordination of benefits (COB) information is one of the top reasons we find for claim denials. Most of these denials are later found to be unnecessary, and are subsequently adjusted to allow payment.

In an effort to reduce the number of rejected claims (which then must be investigated to find proof of other insurance), we have enclosed the Coordination of Benefits Information form. The COB form will help you proactively gather additional insurance information from patients, and should help reduce the number of your claims that are rejected as a result of inaccurate or missing COB information.

If your patients have had any recent insurance benefit changes, please ask them to update their information by completing the form and returning it to us (or their Blue Cross and Blue Shield home plan).

Thank you for your cooperation. If you have questions on the COB form, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.

Sincerely,

Virginia Levi
Assistant Vice President
Customer and Provider Service

Blue Cross Blue Shield of Rhode Island

COORDINATION OF BENEFITS INFORMATION

Your prompt response will ensure that your claims are paid quickly and accurately.

Date:_____

☐ If new address, check here

Member Identification No:_____

Member's name (First and last):

Member's address:

City: State: ZIP:

Complete this section if BCBSRI is the ONLY insurance coverage that you and your dependents have.

Part I:

Subscriber's name (first and last):_____ Date of birth: ____/____/____

Spouse's name (first and last):_____ Date of birth: ____/____/____

Subscriber's signature:_____ Social Security No.:____-____-____

Current employment status of BCBSRI member that is receiving this group-sponsored health coverage:

Actively employed? ☐ Retired? ☐ Disabled? ☐ Disabled and working? ☐

Complete this section if you or any dependents are also covered by another health plan or have been covered within the last 12 months. This includes any other Blue Cross & Blue Shield plan.

Part II: Complete this section if you have another health insurance plan (non-Medicare).

Subscriber's name with other insurance policy:_____

Date of birth: ____/____/____ Social Security No.: ____-____-____

Is this person actively employed? ☐ Retired? ☐ Disabled? ☐ Disabled and working? ☐ Retirement date: ____/____/____

Name of other health insurance plan:_____

Coverage effective dates: From: ____/____/____ to ____/____/____

Street address:_____City:_____ State:____ ZIP:_____

Phone: (____)_____

Policy number:_____ Group number:_____ ID:_____

Type of coverage (Check one): Single ☐ Family ☐ Type of Plan: Hospital ☐ Medical ☐ Dental ☐ Both ☐

Employer providing coverage:_____

Street address:_____City:_____ State:____ ZIP:_____

List family members covered by other plan:

Name (first and last)	Relationship to this subscriber	Relationship to BCBSRI subscriber
1:		
2:		
3:		

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Complete this section if you are divorced or separated and have dependent children covered by your BCBSRI plan. If responsibility is determined by a court order, please attach a copy of the sections of that order which deal specifically with custody and healthcare responsibility. (Complete this section even if it duplicates information reported in Part II of this form.)

Part III: Complete this section if you are divorced or separated with dependent children.

Individual responsible for children's coverage:

Name:_____ Relationship to child:_____

Name of other health insurance providing child's coverage:_____

Effective date of coverage: _____/_____/_____

Street address:_____ City:_____ State:____ ZIP:_____

Policy number:_____ Group number:_____ ID:_____

Type of coverage (Check one): Single ☐ Family ☐ Type of Plan: Hospital ☐ Medical ☐ Dental ☐ Both ☐

	Child's first and last name	Relationship to this subscriber	Relationship to BCBSRI subscriber
1:			
2:			
3:			

Part IV: For Medicare recipients only (Please refer to your Medicare card for the Medicare number.)

Name:_____ Medicare Number:_____

Hospital only (Part A): _____/_____/_____
Medical only (Part B): _____/_____/_____
Hospital and medical (Part A and Part B): _____/_____/_____

Current employment status: Working ☐ Retired ☐
If working, number of employees at place of employment (if known):_____
If retired, retirement date: _____/_____/_____
Are you disabled? Yes ☐ No ☐
If yes, is your disability due to End Stage Renal Disease (ESRD)? Yes ☐ No ☐
If yes, please give your first date of treatment: _____/_____/_____

Spouse's name:_____ Medicare Number:_____

Hospital only (Part A): _____/_____/_____
Medical only (Part B): _____/_____/_____
Hospital and medical (Part A and Part B): _____/_____/_____

Current employment status: Working ☐ Retired ☐
If working, number of employees at place of employment (if known):_____
If retired, retirement date: _____/_____/_____
Are you disabled? Yes ☐ No ☐
If yes, is your disability due to End Stage Renal Disease (ESRD)? Yes ☐ No ☐
If yes, please give your first date of treatment: _____/_____/_____

Signature:_____ **Date:**_____