QualChoice® HEALTH INSURANCE

Coordination of Benefits Questionnaire

When you or family members have health insurance through more than one company, benefits must be coordinated to avoid overpayment. We depend on your help to process your claims correctly. We appreciate your prompt and accurate reply. Please return this questionnaire within 30 calendar days.

Section I: Subscriber Information *(Please print.)*

Name of QualChoice Subscriber (Last, First, Middle Initial)	QualChoice ID No.	Contact Phone No.

Are you, or any member of your family who are covered by QualChoice, also covered by another group health plan or Medicare?

☐ **Yes.** If Yes, complete Section II (if another health plan), or Section III (if Medicare).

☐ **No.** If No, please sign below and return this form to us.

Section II: Other Health Plan *(Please attach a copy of the other insurance ID card.)*

Other Health Plan Name	Other Health Plan Phone No.	Member ID No. (Include alpha prefix if there is one.)

Address	City	State	Zip

Name of Policyholder	Date of Birth (MM/DD/YYYY)	Effective Date of Coverage	If cancelled, give date.

List all family members (include yourself) covered by the other health plan and their relationship to you (the Subscriber). If there is a court order for dependent coverage, send a copy of the order.

Name	Relationship	Custodial Parent	Is there a court order?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section III. Medicare Information. *Please attach a copy of the Medicare ID card.*

Are you actively/presently employed? ☐ Yes ☐ No

List all family members (include yourself) also covered by Medicare.

Name	Medicare ID No.	Medicare eligibility due to:			Effective Date		
		Age 65+	Disability	Renal Disease	Part A	Part B	Part C
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			

Section IV: Authorized Signature

I understand and agree that any omissions or false information knowingly given by myself and/or my eligible dependents on this form may cancel coverage for me and/or my covered dependents.

Subscriber's Signature	Date (MM/DD/YYYY)

Section V: Instructions

You can return this form to us by fax or mail.
Be sure to include all requested items.

QualChoice
Attn: Claims Department
P.O. Box 25610 • Little Rock, AR 72221
Fax: 833.681.2495

IMPORTANT

Failure to respond within 30 calendar days will result in claims being pended/denied until this questionnaire is returned.

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