Request for other coverage information

For your claims to be processed timely, this Coordination of Benefits (COB) form is required if you or dependents on your policy have coverage through another medical health insurance plan.

If you have any questions, please call 800-238-8379, Monday - Friday, between 8 a.m. and 5 p.m.

Policyholder name	**Policy number**

Marital status

☐ Never married ☐ Married ☐ Single ☐ Domestic partner ☐ Separated ☐ Divorced

Section A - Other medical health insurance

Please complete this section if you, your spouse, or dependents have coverage other than this plan. (Use additional paper if necessary.)

First name	**Last name**	**Relationship**	**Effective date** (mm/dd/yyyy)	**Termination date** (mm/dd/yyyy)	**Reside in same household?**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Insurance carrier name	**Phone number**

Insurance carrier address	**City**	**State**	**ZIP**

Policyholder name	**Policyholder ID**	**Date of birth** (mm/dd/yyyy)

Policyholder address	**City**	**State**	**ZIP**

Section B - Dependent children of separated/divorced parents

Please complete this section for any dependent child(ren) listed in Section A whose parents are divorced, legally separated, or who have some other legal reason for providing coverage. (Use additional paper if necessary.)

Dependent first name	**Dependent last name**	**Relationship**	**Other Insurance Carrier**	**Policy ID**	**Effective date** (mm/dd/yyyy)	**Termination date** (mm/dd/yyyy)

Section B - Dependent children of separated/divorced parents (continued)

Other insurance policyholder name

Date of birth (mm/dd/yyyy)

Other insurance responsible due to

☐ Custody ☐ Divorce decree ☐ Child support order

If any of these boxes are checked, please enclose a copy of the complete document that establishes financial responsibility for medical care.

Section C - Medicare

Please complete this section if you or someone on your policy also has Medicare.

First name	Last name	Medicare #		Begin date (mm/dd/yyyy)	End date (mm/dd/yyyy)
			Part A		
			Part B		
			Reason	☐ 65+ ☐ Disability ☐ ESRD	
			Part A		
			Part B		
			Reason	☐ 65+ ☐ Disability ☐ ESRD	
			Part A		
			Part B		
			Reason	☐ 65+ ☐ Disability ☐ ESRD	

Section D - Signature

☐ I certify that the information provided on this form is true, complete and correct.

Signature **Date** (mm/dd/yyyy)

Please return completed and signed form to:

Arkansas Blue Cross Blue Shield
ATTN: COB Department
P.O. Box 2181
Little Rock, AR 72203-9974