BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Visit our Web site at:
www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

_____ ID Number: _____

_____

_____ Date: _____

1. Do you or any dependents have any other group health, dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (1-800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature _____ Date _____

2. Please list the family members covered by the other policy and the type of coverage you have.

_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

For additional family members, attach sheet with information.
* **If you checked Medicare, answer number 7 on page 2.**

3. Name of other policyholder. _____

Other policyholder's date of birth _____ Relationship to you _____

4. Employer name if coverage is provided through an employer. _____

5. Name of other insurance company and effective date of policy. _____ Effective Date _____

If policy is now terminated, please give termination date. _____ ID# _____

6. If there is a divorce or separation, please list who is responsible for the healthcare expenses. _____

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? _____

* * * * * **SECTION PERTAINS TO MEDICARE COVERAGE ONLY** * * * * *

7. Are you actively working? ☐ Yes ☐ No Begin date _____ Last day of active employment _____

8. Are you or any family members covered by Medicare? ☐ No ☐ Yes
If No, please sign and date below. If Yes, please complete the information below.

- Name _____ Date of Birth _____

Medicare Number _____ Part A Effective Date _____

Part B Effective Date _____

Reason for Medicare (check one)
☐ Age
☐ Disability
☐ ESRD date of first dialysis

- Name _____ Date of Birth _____

Medicare Number _____ Part A Effective Date _____

Part B Effective Date _____

Reason for Medicare (check one)
☐ Age
☐ Disability
☐ ESRD date of first dialysis

Your Signature _____ **Date** _____

*****Please mail or fax this form to the correct plan listed below.*****

- **State Health Plan ("ZCS" Alpha Prefix)**

  State Health Plan: AX-B10
  ATTN: COB
  P.O. Box 100605, Columbia, SC 29260-0605
  FAX (803) 699-7675

- **Federal Employee Plan/FEP ("R" Alpha Prefix)**

  Federal Employee Customer Service
  P.O. Box 100603
  Columbia, SC 29260-9982
  FAX (803) 736-8341

- **Small Group and Individual ("ZCY" Alpha Prefix)**

  Group and Individual: AF-225
  ATTN: COB
  P.O. Box 100246, Columbia, SC 29202-3246
  FAX (803) 264-0172

- **Preferred Blue® and all other BlueCross (Include name of health plan.)**

  BlueCross BlueShield of South Carolina
  P.O. Box 100300
  Columbia, SC 29202
  FAX (803) 264-9128

Clear Form