MAGELLAN HEALTH SERVICES

Insert Date

Group Name: _____
COB#_____

Insert Name
Insert Address
Insert Address

Dear Member:
Your behavioral health plan, administered by Magellan Behavioral Health Systems, LLC, contains a coordination of benefits (COB) provision, applied to situations where there may be overlapping coverage. To ensure accurate processing of claims without COB delays, please complete the following information within 10 business days and return it to us at the following address:

Magellan Behavioral Health Systems, LLC.
P.O. Box 1009
Maryland Heights MO 63043

If you have any questions regarding this form, or if you would like to provide this information telephonically, please call the Magellan phone number on your membership card. Failure to return this form may result in future claims delay.

Section I
Is any member of your family covered by another group health plan, Medicare or Medicaid?
___No (Please continue to Section III) ____Yes (please give name and relationship of those family members covered.)

_____

_____

If a child is listed above, is this a dependant child (children) whose natural parents are divorced or separated? Yes___ No___
If so, has a court ordered the responsibility for providing health care coverage of this child (children)?
If yes: Court Ordered Father to provider insurance_____. Court Ordered Mother to provider insurance_____.
If no: Which parent has court ordered custody? _____ Name of parent _____
Does anyone other than the natural parents or step-parents carry insurance on the dependent (s)?
If so, whom? _____ if so, please complete Section II.

Section II
Complete the following for all other coverage.
Policy Holder Name _____Policy Holder Social Security Number _____

Employer's Name

_____

Address _____City _____State _____Zip_____
Group/Policy Number _____Phone Number of Insurance Company_____
Effective date _____
Type of Coverage: Single _____ Family _____

Section III
Is any member of your family covered by Medicare?
____No (please continue to section IV) _____Yes (please complete the following)
Name of Medicare Subscriber _____ Date of Birth _____
Medicare ID # _____
Part A effective date _____ Part B effective date _____
Is Medicare due to a disability? No _____ Yes _____ (date of onset)
_____
Are you employed or retired? _____

Section IV
Subscriber's Signature/ & I.D.
#_____Date _____