Coordination of Benefits for Other Insurance Coverage

If you have other Insurance In addition to your **UnitedHealthcare** coverage, we will need your other Insurance Information. By coordinating benefits among all Insurance carriers, the insured receives the maximum benefits available.

• Indicates required fields, as applicable

PATIENT: *Name of Patient:_____ *Date of Birth: _____

INSURED: *Name of Insured:_____ * Phone #: _____

*Relationship to Patient: □Self □Spouse □Parent □Other _____

Group or Claim#:_____ Subscriber/ Member #: _____

***Does the Patient have other Insurance** or **Medicare coverage?**

□ YES » continue with form

□ NO » Go to **Signature** section

OTHER INSURANCE CARRIER:

- Name of the Subscriber for the other Insurance policy •_____
- Name of the Employer: _____
- Name of Other Insurance Carrier: _____
- Insurance Carrier claim address: _____

Insurance Carrier phone number: _____

*Policy Number:_____ *Group Number: _____

*Beginning date of Coverage:_____ *End date of Coverage (Jr applicable):_____

Other Insurance covers? □ Self □ Spouse □ Child □ Other_____

PHARMACY

Pharmacy name:_____ Pharmacy phone number: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name or Dependent(s): _____

Relationship or other Insurance member to child: □Parent □Stepparent □Legal Guardian □Other _____

Child resides with: □Parent □Stepparent □Legal Guardian □Other _____

Person(s) with legal custody: □Parent □Stepparent □Legal Guardian □Other _____

Is there a court decree that assigned primary responsibility for health care coverage? □ Yes □ No

Relationship of party with decreed responsibility: □Parent □Stepparent □Legal Guardian □Other _____

Name of responsible party: _____

Address: _____

Name and date of birth of both parents	Mother's Name: Date of Birth:	Father's Name: Date of Birth:

MEDICARE,

*Name or Individual covered by Medicare:_____

*Medicare ID#:_____

Date of Birth:_____ Date of Retirement (If applicable):_____

*Medicare Part A effective date (If applicable):_____

*Medicare Part B effective date (If applicable): _____

*Medicare Part D Prescription Drug Coverage effective date (if applicable):_____

•Entitlement Reason: □Age

□Disability Date disability began: _____

□End Stage Renal Disease First date of dialysis: _____

Kidney transplant date: _____

SIGNATURE:

•Insured or Patient Name (print):_____

*Signature of Insured or Patient:_____ *Date: _____