South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

**Visit our website 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 (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 a separate sheet with the information.

* **If you checked Medicare, answer question #7 on page 2.**

3. Name of Other Policyholder: _____

Other Policyholder's Date of Birth: _____ Relationship to You: _____

4. Employer's 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. The Other Insurance Company's Address: _____
7. The Payor ID for the Other Insurance Company (if known): _____
8. If there is a divorce or separation, please list who is responsible for the health care 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** * * * * *

9. Are you actively working? ☐ Yes ☐ No Start Date: _____ Last Day of Active Employment: _____

10. 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:**

- **State Health Plan ("ZCS" and "ZCK" Prefix)**

**State Health Plan: AX-B10**
**ATTN: COB**
**P.O. Box 100605, Columbia, SC 29260-0605**
**Fax: 803-264-4204**

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

**Federal Employee Customer Service: AX-B05**
**P.O. Box 100603**
**Columbia, SC 29260-9982**
**Fax: 803-736-8341**

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

**Group and Individual: AX-F25**
**ATTN: COB**
**P.O. Box 100246, Columbia, SC 29202-3246**
**Fax: 803-264-0172**

- **Preferred Blue® and All Other BlueCross Plans (Include name of health plan.)**

**BlueCross BlueShield of South Carolina**
**P.O. Box 100300**
**Columbia, SC 29202**

Check your member ID card for Service Center location:
**Piedmont (Greenville) Service Center: Fax: 803-264-9128**
**Columbia Service Center: Fax: 803-264-6572**