HIGHMARK® Delaware

COORDINATION OF BENEFITS QUESTIONNAIRE

Your Name: _____ Highmark Member ID #: _____

A. Within the past year, have you or any member of your family been covered by another insurance company?

- ❑ **No.**
- ❑ **Yes.** Please complete the remainder of this questionnaire.

B. Check which of the following plans provide benefits for you or any member of your family:

❑ **Another Highmark Blue Cross Blue Shield Delaware contract?**

ID #: _____

❑ **Medicare?**

HIC #: _____ Part B effective date (mo., day, yr.): _____

❑ **Another health insurer?**

Name of other health insurance company: _____

Name of other employer: _____

Address where claims are submitted: _____

Name of policyholder: _____

Policyholder's date of birth (month, day, year): _____

Policyholder's ID #: _____

Effective date of policy (month, day, year): _____

Cancellation date, if applicable (month, day, year): _____

Name of person(s) covered:

Spouse : _____

Dependent Child(ren): _____

You must download this form to your computer and open in Adobe Acrobat to make the fields fillable.

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C. COURT ORDER / CUSTODY FOR DEPENDENT CHILDREN - Select only one if applicable

- ❑ Court Order - List individual with primary medical responsibility. (Attach Court Order)
- ❑ Joint Custody - List individuals with custody responsibility.
- ❑ Individual Custody - List individual with whom children primarily reside.

Responsible Parent/Guardian(s) First Name	Last Name	**Relation to Child** (Ex. Mother, Father)	**Date of Birth** (mm/dd/yyyy)	**Court Order/Custody** Effective Date (mm/dd/yyyy)

List Children affected by Court Order/Custody.

Child's Name First	Last	**Child's Name** First	Last	**Child's Name** First	Last

List other insurance policy covering children affected by court Order/Custody

PolicyHolder's Name First	Last	Policy Holder's Sex (Ex. Male, Female)	Policy Holder Relationship to Child	Policy Holder Date of Birth (mm/dd/yyyy)

Policy Holder Insurance Carrier Name	Policy Holder Identification Number	Policy Effective Date Date (mm/dd/yyyy)	Policy Type(s) of Coverage
			❑ Medical ❑ Drug

Your signature:_____

Daytime telephone number: ( )_____

Please return this survey to:
Highmark Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

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We thank you for the time spent completing this questionnaire.