

UPMC HEALTH PLAN

Coordination of Benefits Verification

UPMC Health Plan wants to make sure that your claims are processed timely and accurately, especially when you are covered by more than one health insurance plan. Please complete this form to help UPMC Health Plan ensure that your health insurance claims are processed correctly. **Failure to complete and return this form may result in denial of claim payments.**

Thank you for your assistance in providing this information. If you have questions or concerns, call UPMC Health Plan at 1-888-876-2756. Please return this survey to the Coordination of Benefits Department at the address or fax number listed at the end of this survey.

UPMC Health Plan Policyholder Name: _____

Member ID Number: _____ **Date of Birth:** _____

Other Insurance Information

If you need additional space, please attach a separate sheet of paper.

1. Are you or any family member covered by another health insurance plan (i.e., major medical plan, dental plan, vision plan, Medicare, HMO, PPO, POS, or indemnity health plan)?

Yes No

If you answered no, you are finished with this inquiry. Please return this verification form to UPMC Health Plan at the address or fax number listed at the end of this survey.

2. If yes, please provide information on the other health insurance policy(ies) covering you and/or your family.

Plan Type: _____

Name of Insurance Carrier: _____

Address of Insurance Carrier: _____

Phone Number of Insurance Carrier: _____

Member ID Number: _____

Effective Date: _____

Policyholder Name: _____

Family Members Covered by the Plan: _____

Does this policy include coverage for prescription drugs? Yes No

Does this policy include coverage for dental? Yes No

Does this policy include coverage for vision? Yes No

3. Do you or a family member have a separate insurance policy (other than listed previously) that covers prescription drugs?

Yes No

If yes, please complete the information below.

Name of Prescription Drug Plan: _____

Phone Number of Prescription Drug Plan: _____

Member ID Number: _____

Effective Date: _____

4. Do you or a family member have a separate insurance policy (other than listed previously) that covers dental services?

Yes No

If yes, please complete the information below.

Name of Dental Plan: _____

Phone Number of Dental Plan: _____

Member ID Number: _____

Effective Date: _____

5. Do you or a family member have a separate insurance policy (other than listed previously) that covers vision services?

Yes No

If yes, please complete the information below.

Name of Vision Plan: _____

Phone Number of Vision Plan: _____

Member ID Number: _____

Effective Date: _____

6. Does anyone in your family have coverage under Medicare?

Yes No

If yes, please complete the information below for each person with Medicare coverage.

Beneficiary Name: _____

Medicare Health Insurance Claim Number (HICN): _____

Coverage (circle one): **Part A only** **Part B only** **Parts A and B**

Effective Date: _____

Reason for Medicare Coverage (circle all that apply):

Over age 65 **Disability** **End Stage Renal Disease (ESRD)**

If entitled due to ESRD, please provide the following information.

Original Dialysis Date: _____

Type of Dialysis (circle one):

Hemodialysis (center-based)

CCPD

CAPD

Kidney Transplant:

Yes No

If yes, date: _____

7. Do you have dependent children whose health insurance coverage is provided by another person due to divorce, court decisions, or custody agreements?

Yes No

If yes, please complete the information below.

Name of Person Responsible for Insurance Coverage: _____

Plan Type: _____

Name of Insurance Carrier: _____

Member ID Number: _____

Effective Date: _____

Policyholder Name: _____

Family Members Covered by the Plan: _____

Address of Insurance Carrier: _____

Phone Number of Insurance Carrier: _____

Does this policy include coverage for prescription drugs? Yes No

Does this policy include coverage for dental? Yes No

Does this policy include coverage for vision? Yes No

8. If dependent children are covered by more than one insurance and there is not a court order in place, who has physical custody of the dependent children?

Name of Person with Physical Custody: _____

Relationship to Dependent Children: _____

To the best of my knowledge, all statements made within this verification are true and accurate.

Policyholder Signature: _____ Date: _____

Thank you for taking the time to complete this verification form. Please send or fax it to:

**UPMC Health Plan
Coordination of Benefits
One Chatham Center, 5th Floor
112 Washington Place
Pittsburgh, PA 15219
Fax: 412-454-7770**