

**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 obtaining this information. If you have questions or concerns, please call Member Services 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 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)?

Please circle one:      **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. 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 Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Family Members Covered by the Plan: \_\_\_\_\_

Does this policy include coverage for prescription drugs (circle one)?    **Yes**    **No**

Does this policy include coverage for dental (circle one)?    **Yes**    **No**

Does this policy include coverage for vision (circle one)?    **Yes**    **No**

3. Do you or a family member have a separate insurance policy (other than listed previously) that covers prescription drugs (circle one)?    **Yes**    **No**

If **Yes**, please complete the information below.

Name of Prescription Drug Plan: \_\_\_\_\_

Phone Number of Prescription Drug Plan: \_\_\_\_\_

Member Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

4. Do you or a family member have a separate insurance policy (other than listed previously) that covers dental services (circle one)?    **Yes**    **No**

If **Yes**, please complete the information below.

Name of Dental Plan: \_\_\_\_\_

Phone Number of Dental Plan: \_\_\_\_\_

Member Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

5. Do you or a family member have a separate insurance policy (other than listed previously) that covers vision services (circle one)?    **Yes**    **No**

If **Yes**, please complete the information below.

Name of Vision Plan: \_\_\_\_\_

Phone Number of Vision Plan: \_\_\_\_\_

Member Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

6. Does anyone in your family have coverage under Medicare (circle one)? **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** **Part 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 (circle one): **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 (circle one)? **Yes** **No**

If **Yes**, please complete the information below.

Name of Person Responsible for Insurance Coverage: \_\_\_\_\_

Plan Type: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Member 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 (circle one)? **Yes** **No**

Does this policy include coverage for dental (circle one)? **Yes** **No**

Does this policy include coverage for vision (circle one)?

**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.**

**UPMC Health Plan**

**Coordination of Benefits**

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