Coordination of Benefits Questionnaire

FAILURE TO COMPLETE, SIGN AND RETURN THIS QUESTIONNAIRE WILL DELAY CLAIM PAYMENTS

PLEASE PRINT

Member Name: _____ Iron Road Healthcare Member ID #: _____
Email: _____ Phone: _____

Other Insurance:

Are you or any other member of this IRHC policy covered by another medical or prescription insurance policy currently or during the past 2 years?

- ☐ NO If No, please complete **Section B**, then print, sign, date and return this questionnaire to IRHC.
- ☐ YES If Yes, please complete all the fields below that pertain to the member(s) with other coverage. Print sign, date and return this questionnaire to IRHC.

Section A

Check those that apply:

☐ Other Health Insurance ☐ Group Health Insurance ☐ Individual Policy
☐ Student Policy ☐ Medicare Supplemental ☐ Prescription Coverage

Other Insurance Name: _____
Policy #: _____
Address: _____
City: _____ State: _____ Zip code: _____

Phone Number: (_____) _____-_____

Dependent(s) listed on the other insurance: Effective Date Cancelation Date
_____ ____/____/_____ ____/____/_____
_____ ____/____/_____ ____/____/_____
_____ ____/____/_____ ____/____/_____

Other Insurance Policyholder's Name: _____
Policyholders Date of Birth: _____/_____/_____ ID #: _____
Effective Date of Other Insurance: _____/_____/_____
If Cancelled, Cancellation Date: _____/_____/_____

Is the policyholder:

- ☐ Actively working for the group
- ☐ Inactive
- ☐ Retired, Retirement Date: ____/____/_____
- ☐ On COBRA, Effective Date: ____/____/_____

Policyholder's Employer: _____

Employer's Address: _____

City, State, & Zip code: _____

Court Ordered Information

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? ☐ Yes ☐No

If yes, list the name(s) of the dependent(s) that this applies to: _____

_____

If yes, who is the person(s) ordered to maintain health coverage? _____

What is the relationship to the child(ren)? _____

Who has custody of the child(ren)? _____

Documentation of the court order may be requested by IRHC

Section B

Name(s) of Dependent(s) on IRHC Policy

Name Relationship Date of Birth Gender

_____ _____ ____/_____/_____ _____

_____ _____ ____/_____/_____ _____

_____ _____ ____/_____/_____ _____

_____ _____ ____/_____/_____ _____

_____ _____ ____/_____/_____ _____

Section C

Medicare Information

Does the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare: _____

Medicare Number, including alpha character(s): _____

Effective Date of Medicare Part A: _____/_____/_____

Effective Date of Medicare Part B: _____/_____/_____

Effective Date of Medicare Part D: _____/_____/_____

* Is Medicare awarded based on Disability or ESRD? Please provide the following:

1st Date of Disability: _____/_____/_____

1st Date of Dialysis for ESRD: _____/_____/_____

Was Dialysis started in a Facility? ☐ Yes ☐ No

Was Dialysis started as Self Dialysis or Home Dialysis ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of transplant: _____/_____/_____

If yes; please provide the name of transplant facility: _____

IRHC Member Signature: _____

Date: ____/_____/_____

REMEMBER TO COMPLETE, SIGN AND DATE THIS FORM BEFORE RETURNING TO IRHC

If additional space is needed, please attach a paper with the details to this form.