SummaCare℠

Do you or a member of your family currently have healthcare coverage with another plan?
☐ YES- complete form below
☐ NO- return this form signed and dated below

COORDINATION OF BENEFITS FORM

CONTRACT HOLDER NAME:	CONTRACT NUMBER:

OTHER INSURANCE CARRIER INFORMATION (Space for more than one carrier is provided)

POLICY 1- POLICY HOLDER NAME:	POLICY 2- POLICY HOLDER NAME:
DATE OF BIRTH: / /	DATE OF BIRTH: / /
STATUS: ☐ Active ☐ Retired ☐ COBRA	STATUS: ☐ Active ☐ Retired ☐ COBRA
OTHER POLICY COVERS: ☐ Hospital ☐ Medical ☐ Dental ☐ Vision ☐ Drug	OTHER POLICY COVERS: ☐ Hospital ☐ Medical ☐ Dental ☐ Vision ☐ Drug
GROUP NUMBER:	GROUP NUMBER:
POLICY HOLDER NUMBER:	POLICY HOLDER NUMBER:
EFFECTIVE DATE:	EFFECTIVE DATE:
TERMINATION DATE:	TERMINATION DATE:
NAME OF INSURANCE COMPANY:	NAME OF INSURANCE COMPANY:
CITY, STATE, ZIP:	CITY, STATE, ZIP:
PHONE NUMBER:	PHONE NUMBER:
IS THIS A MEDICAID PLAN? ☐ Yes ☐ No	IS THIS A MEDICAID PLAN? ☐ Yes ☐ No
INDICATE WHETHER THE OTHER INSURANCE IS: ☐ Single (skip section below) ☐ Family	INDICATE WHETHER THE OTHER INSURANCE IS: ☐ Single (skip section below) ☐ Family

FAMILY INFORMATION If other insurance is family coverage, please fill in the section below. If there is a court order designating responsibility for a child's healthcare, attach a copy of the document.

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	POLICY (1 OR 2)	ACTIVE COURT ORDER (YES OR NO)

MEDICARE INFORMATION If Medicare covers you or a member of your family, complete this section. Information can be found on your health insurance identification card from Medicare.

CARDHOLDER NAME	MEDICARE ID	EFFECTIVE DATES	MEDICARE REASON
		Part A: / / Part B: / / Part D: / /	☐Age ☐Disability ☐ESRD
		Part A: / / Part B: / / Part D: / /	☐Age ☐Disability ☐ESRD

I certify the above information is correct and complete to the best of my knowledge.

FULL NAME (PRINTED) _____

SIGNATURE _____ DATE _____