COORDINATION OF BENEFITS

Apply Patient Label

By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.
* Information on this form needs to match the information on the insurance card*

Patient's Last Name: ________________________ First Name: ________________________ Patient's Date of Birth: ___________________

PRIMARY INSURANCE

Subscriber's Full Name: ____ Subscriber's DOB: _______________

Relationship to Patient: ☐ Self ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other ____________________________

Subscriber's Phone #: ________________________ Subscriber's Employer: ________________________

Primary Insurance Plan: ________________________ Subscriber/Member ID#: ________________________ Group # ________________

Insurance Billing Address: ____ Insurance Phone # __________________________

Name and Date of Birth of both Parents/Legally Authorized Representatives	Parent/LAR Name: ________________________ Date of Birth: ____________________________	Parent/LAR Name: ______________________________ Date of Birth: __________________________________

Email Address of Parent/LAR: ____________________________ **Email Address of Parent/LAR:** ___________________________

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND PHOTO ID TO THE REGISTRAR

Please provide the patient's CRS (Children's Rehabilitative Services) ID# (if applicable.) ____________________________________

OTHER INSURANCE:

Subscriber's Full Name: ____ Subscriber's Date of Birth: ______________

Subscriber's Phone #: ________________________ Subscriber's Employer: __________________________

Other Insurance Plan: ________________________ Subscriber/Member ID#: ________________________ Group # __________________

Insurance Billing Address: ____ Insurance Phone # __________________________

*****If the patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following.*****

Relationship of other insurance member to child: ☐ Self ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _________

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _________

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _________

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes ☐ No

Relationship of party decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _________

Name of responsible party: ____

Address: ____ Phone #: ________________________

Does the Patient have MEDICARE? ☐ YES ☐ NO **If Yes, is Medicare Primary?** ☐ YES ☐ NO

Name of Individual Covered by Medicare: ____ Date of Birth: ____________________________

Medicare ID#: _____________________________

☐ Part A_______________ ☐ Part B _______________ ☐ Part D *(Prescription Drug Coverage)* _______________
Effective Date *Effective Date* *Effective Date*

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease

Date disability began: ___________________
First date of Dialysis: ___________________
Kidney Transplant Date: ___________________

****Medicare Secondary Payer Questionnaire Must Be Completed****

____ ____ ______________________
Signature of Person Completing Form **Printed Name** **Date/Time**

PCH10745 (Rev. 4 (07/2017)