



South Carolina

Blue Cross Blue Shield of South Carolina is an Independent licensee of the Blue Cross and Blue Shield Association

Visit our website at: www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ID Number: \_\_\_\_\_

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

1. Do you or any dependents have any other group health, dental or Medicare coverage?  No  Yes

**IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.**

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. Please list the family members covered by the other policy and the type of coverage you have.

_____	<input type="checkbox"/> Medical	<input type="checkbox"/> Hospital	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare
_____	<input type="checkbox"/> Medical	<input type="checkbox"/> Hospital	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare
_____	<input type="checkbox"/> Medical	<input type="checkbox"/> Hospital	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare
_____	<input type="checkbox"/> Medical	<input type="checkbox"/> Hospital	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare
_____	<input type="checkbox"/> Medical	<input type="checkbox"/> Hospital	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare

For additional family members, attach a separate sheet with the information.  
\* If you checked Medicare, answer question #7 on page 2.

3. Name of Other Policyholder: \_\_\_\_\_

Other Policyholder's Date of Birth: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

4. Employer's Name, If Coverage is Provided Through an Employer: \_\_\_\_\_

5. Name of Other Insurance Company and Effective Date of Policy: \_\_\_\_\_ Effective Date: \_\_\_\_\_

If policy is now terminated, please give termination date: \_\_\_\_\_ ID#: \_\_\_\_\_

6. The Other Insurance Company's Address: \_\_\_\_\_

7. The Payor ID for the Other Insurance Company (if known): \_\_\_\_\_

8. If there is a divorce or separation, please list who is responsible for the health care expenses: \_\_\_\_\_

If there is a copy of a divorce decree, please forward a copy to us.  
If there is not a court decree, who has custody of the children?

\_\_\_\_\_

\*\*\*\*\* SECTION PERTAINS TO MEDICARE COVERAGE ONLY \*\*\*\*\*

9. Are you actively working?  Yes  No Start Date: \_\_\_\_\_ Last Day of Active Employment: \_\_\_\_\_

10. Are you or any family members covered by Medicare?  No  Yes  
If No, please sign and date below. If Yes, please complete the information below.

• Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_  
Part B Effective Date: \_\_\_\_\_  
Reason for Medicare (check one):  Age  Disability  ESRD Date of First Dialysis: \_\_\_\_\_

• Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_  
Part B Effective Date: \_\_\_\_\_  
Reason for Medicare (check one):  Age  Disability  ESRD Date of First Dialysis: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax this form to the correct plan:

- State Health Plan ("ZCS" and "ZCK" Prefix) State Health Plan: AX-B10  
ATTN: COB  
P.O. Box 100605, Columbia, SC 29260-0605  
Fax: 803-264-4204
- Federal Employee Plan/FEP ("R" Prefix) Federal Employee Customer Service: AX-B05  
P.O. Box 100603  
Columbia, SC 29260-9982  
Fax: 803-736-8341
- Small Group and Individual ("ZCY" Prefix) Group and Individual: AX-F25  
ATTN: COB  
P.O. Box 100246, Columbia, SC 29202-3246  
Fax: 803-264-0172
- Preferred Blue® and All Other BlueCross Plans (Include name of health plan.) BlueCross BlueShield of South Carolina  
P.O. Box 100300  
Columbia, SC 29202

Check your member ID card for Service Center location:  
Piedmont (Greenville) Service Center: Fax: 803-264-9128  
Columbia Service Center: Fax: 803-264-6572