sidecar health.

Coordination of Benefits Questionnaire

This form should be completed by the subscriber/main policyholder of Sidecar Health coverage

SEND COMPLETE FORM TO:
Sidecar Health
claims@sidecarhealth.com

Sidecar Health Member Name:	
Sidecar Health Policy ID#:	
Sidecar Health Member DOB:	

Your Sidecar Health major medical plan contains a Coordination of Benefits (COB) provision. If you or your dependents have other health insurance, this form is required to process your claims accurately. Please contact Member Care at 877-553-8246 with questions.

OTHER INSURANCE: (PLEASE PRINT USING INK)
Are you or any other member of this Sidecar Health plan covered by another major medical health insurance policy?

☐ **No.** If *No*, sign, date and return this questionnaire to us, indicating "No" by selecting the box to the left of this text.

☐ **Yes.** If *Yes*, please make any revisions necessary to the information in Section A and B and complete all the relevant fields below for the member(s) with the other coverage.

Subscriber
Signature Required: _____ Date _____

SECTION A

NAME OF SPOUSE OR DEPENDENT(S) ENROLLED IN SIDECAR HEALTH PLAN

Name	Relationship to You	Date of Birth	Sex	Social Security # (Optional)

SECTION B

IF THIS DOES NOT APPLY, SKIP TO SECTION C.

Who has other health insurance? ☐ Myself ☐ Dependent(s) ☐ Spouse *(check all that apply)*

Type of other health insurance: ☐ Employer/Group ☐ Individual/Exchange Policy ☐ Medicaid, Children's Health Insurance Program (CHIP), or other state-based health program ☐ Medicare *(if Medicare, complete Section C below)*

Other Health Insurance Carrier Name _____

Address _____

City, State, Zip _____ Phone Number _____

Spouse or Dependent(s) on other insurance:	Effective or Cancel Date, if different from policyholder:

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth _____ ID# _____

Effective Date of Other Insurance _____ If Canceled, Cancellation Date _____

Your Relationship to Other Policyholder *(list "self" if you are the main policyholder of other insurance)*: _____

Your Dependent(s) Relationship to Other Policyholder *(if dependents have other insurance)*: _____

Your Spouse's Relationship to Other Policyholder *(if spouse has other insurance)*: _____

Is the other policyholder:

☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: _____

☐ On COBRA, which began _____

Policyholder's Employer _____

Employer's Address _____

City, State, Zip _____

SECTION C

IF THIS DOES NOT APPLY, SKIP TO SECTION D.

MEDICARE INFORMATION

Does the policyholder 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 C _____ Effective Date of Medicare Part D _____

Medicare Entitlement ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability _____

1st Date of Dialysis for ESRD _____

Was ESRD started in a facility? ☐ Yes ☐ No

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

Has a transplant been performed? ☐ Yes ☐ No

If *yes*, please provide date of the transplant. _____

IN ADDITION, PLEASE PROVIDE A COPY OF THE MEDICARE CARD

SECTION D

COURT ORDER INFORMATION

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

List the name(s) of the dependent(s) to whom the Court Order applies. _____

_____

_____

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

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

Who has custody of the child(ren) more than 50% of the time? _____

DOCUMENTATION OF THE COURT ORDER MAY BE REQUESTED.