

Date _____ Adj. _____
Patient Name _____ Rel. _____
Group & ID No. _____
Claim No. _____

Dear Member:

Your health coverage includes a Coordination of Benefits provision in accordance with Oregon state insurance regulations. In order for us to process your claim(s), we need the following information to determine the primary carrier as prescribed by law. We routinely investigate to update our records. Please complete and sign this form, even if you have received similar forms in the past. PLEASE RETURN THIS FORM WITHIN 15 DAYS, OR CALL OUR OFFICE AT THE TELEPHONE NUMBER LISTED ON YOUR IDENTIFICATION CARD. You may also submit this information using our online form at www.or.regence.com/member/form.

Do you or any family members have any other health coverage, or has any such coverage existed during the last 12 months? Include any coverage with Regence BlueCross BlueShield of Oregon (Regence BCBSO), any other insurance company, any Blue Cross and/or Blue Shield coverage, any retirement plan, or Medicare coverage.

YES (please complete form and supply policy information below) NO (please sign last page and mail in enclosed envelope)

Insurance Information

P O L I C Y 1	Effective Date		Cancellation Date		
	Name of Insurance Company				
	Insurance Address		City	State	Zip Code
	Insurance Telephone Number ()		ID Number	Group Number	
	Name of Policyholder			Date of Birth	
	Employer's Name				

Type of Coverage:

Medical Dental Vision Prescription Medicare* (If checked, complete Medicare Certification Information on next page.)

Type of Policy: Group/Employer Individual Retiree COBRA

Persons Covered by Other Insurance

Name	Social Security Number	Relationship	Date of Birth

Insurance Information

P O L I C Y 2	Effective Date		Cancellation Date		
	Name of Insurance Company				
	Insurance Address		City	State	Zip Code
	Insurance Telephone Number ()		ID Number	Group Number	
	Name of Policyholder			Date of Birth	
	Employer's Name				

Type of Coverage:

Medical Dental Vision Prescription Medicare* (If checked, complete Medicare Certification Information on next page.)

Type of Policy: Group/Employer Individual Retiree COBRA

Persons Covered by Other Insurance

Name	Social Security Number	Relationship	Date of Birth

Child Custody Information

If your dependent child(ren) are covered under another plan and the natural parents are divorced or separated, Oregon state regulations require that we ask the following:

Name of parent with custody* (If parents have dual custody, indicate) _____

If divorced, did the court establish financial responsibility for the children's health care?

NO YES (If yes, please specify the name of person with financial responsibility) _____

Date of Divorce _____ (Include a copy of the child maintenance agreement form from the divorce decree).

Address of person with financial responsibility _____

Medicare Certification

If you or any family members are covered by MEDICARE, please provide the following information:

Member's Name _____ Medicare Number _____

Part A Effective Date _____ Part B Effective Date _____

I am entitled to Medicare coverage due to: Age Disability ESRD

Member's Name _____ Medicare Number _____

Part A Effective Date _____ Part B Effective Date _____

I am entitled to Medicare coverage due to: Age Disability ESRD

I am not entitled to Medicare for the following reasons:

- I am not yet 65 years of age.
- I have never contributed to Social Security through employment.
- Neither I, nor my spouse, have worked sufficient time for me to qualify.
- I should be eligible for Medicare but I have not yet enrolled.

I/We certify that the above information is true and correct to the best of my knowledge.

Insured's Signature  _____ Date _____

Work Telephone Number () _____ Home Telephone Number () _____

E-Mail Address _____

Please return to: PO Box 1271
Portland Oregon 97207-1271

Questions, please call: (503) 225-5336 or toll free (800) 452-7390