Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

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Coordination of Benefits Form

Coordination of benefits is the process of establishing primary and secondary coverage with regards to the order of the payment of claims. If you or any of your covered dependents have other medical, prescription, dental or vision coverage, we must have the following information on file to ensure the proper processing of your claims.

SECTION 1: MEMBER INFORMATION

Member's Full Name		Date of Birth	SSN (last 4 digits)
Mailing Address	City	State	Zip Code
Primary Phone	E-mail Address		

SECTION 2: OTHER INSURANCE ATTESTATION

Do you or any of your dependents have any other medical, dental, prescription, or vision insurance coverage? (Check all that apply.)

- ❑ YES, I am enrolled in another health insurance plan. (continue to Section 3)
- ❑ YES, my spouse or ex-spouse is enrolled in another health insurance plan. (continue to Section 3)
- ❑ YES, my dependent(s) are enrolled in another health insurance or State plan. (continue to Section 3)
- ❑ NO, neither myself nor <u>any</u> of my covered dependent(s) are enrolled in any other medical, prescription, dental or vision insurance besides the coverage provided through Allegiant Care (Skip to Section 5)

SECTION 3: OTHER INSURANCE INFORMATION (List each insurance company separately)

1. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

2. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

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SECTION 3: OTHER INSURANCE INFORMATION (CONT.)

3. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

4. Insurance Carrier Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

SECTION 4: MEDICARE COVERAGE

Are you or any dependents (including spouse) enrolled in Medicare? ❑ Yes ❑ No (if no, skip to Section 5)

1. Name of Eligible Person			Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)	
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

2. Name of Eligible Person			Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)	
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

2. Name of Eligible Person			Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)	
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

SECTION 5: CERTIFICATION

I certify that the information provided on this form is complete and accurate. I understand that I am obligated to notify Allegiant Care of any changes within 30 days of the change (gain or loss of other coverage for myself or any of my dependents). Failure to do so may result in the denial of claims or recoupment of benefits paid.

Member Signature: _____ **Date:** _____

Upload your completed and signed form at www.myallegiantcare.com/send.
You may also return your completed form to the mailing address noted above.
Retain a copy of this form for your records.