Coordination of Benefits Questionnaire

Coordination of Benefits
1749 38th Street S.
Fargo ND 58103

Customer Service: (800) 752-5863
NDPERS Customer Service: (800) 499-3416
ND Medicaid Expansion Customer Service: (855) 305-5060

If you have insurance coverage with another health plan or Medicare, you must inform us to coordinate your benefits and share the cost of your health care. **In order to process claims correctly, please complete and return this form as soon as possible, as future claims will not be processed if this form is not received.**

Member Name: ________________________________ Address: ______________________________________

City: ____ State: _______________ Zip: ________________________

Member ID Number:____

Type of Health Coverage

While covered by Sanford Health Plan, have you or any of your family members been covered by another:
Health Plan (including Medicare) □ Yes □ No **Dental Plan** □ Yes □ No **Prescription Plan** □ Yes □ No

If you checked **"Yes"** to any box above, please complete all applicable fields on the form. If you checked **"No"** in all the boxes above, please sign and date the form. When complete, return to Sanford Health Plan:

- By mail at the address above
- By fax at (701) 282-8063
- By emailing this form or necessary information to Healthplancob@sanfordhealth.org
- By contacting Customer Service using the information above.

Other Coverage/Medicare Information

Name of other insurance company:			Effective date of other coverage:
Phone number of other insurance company:			Policyholder's name with other insurance:
First and last names of members on this policy:			
Policyholder's date of birth with other insurance:			Member ID number:
Medicare ID number:	Medicare Only - Effective date(s):		
	Part A:	Part B:	Part C:

Divorce Decree/Child Support Orders/Court Orders

Is there a divorce decree/ child support order /court order that orders one or both parents to provide health insurance for any covered dependents: □ Yes □ No

- **If yes, a copy of the divorce decree/ child support order /court order is REQUIRED and will only be used for claims processing.**

Person(s) required to carry health insurance per divorce decree/court order (first and last name(s))

Person with Primary Physical Custody:

Signature

Subscriber Signature:	Date:

Questions? Please contact Customer Service for assistance.