Harvard Pilgrim Health Care

Name: _____ Date: _____

Address: _____ HPHC #: _____

_____

Your Harvard Pilgrim Health Care membership contains a provision that is required by State & Federal regulations to coordinate medical/dental benefits for its members who are covered by any other health, dental and/or Medicare insurance. ***In order to process claims, the following information is required. Please assist us in filling out this form.***

Do you or any members of your family have health or dental insurance in addition to your HPHC coverage?

____ No, Please sign, date and return in the envelope provided.

____ Yes, Please complete all sections that apply to you and/or your family and return in the envelope provided.

Is the subscriber of the HPHC policy actively working? _____Yes _____No

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1. Other Commercial Insurance (other than this HPHC policy for ALL family members):

Name of Insurance Co.: _____ Phone #: _____ Health: ____ Dental ___
Policy Holder's Name: _____ Date of Birth: _____
Policy #: _____ Effective Date: _____Social Security #:_____
Individuals Covered:_____

Is there a legal document indicating who is responsible for health coverage for any dependents on your HPHC Policy (i.e. divorce/guardianship)?If yes, please give the name of the responsible party: _____
Name of Insurance: _____Policy #: _____Phone #: _____
Effective Date: _____Was sole custody, joint custody or guardianship granted? _____
If yes, who has custody? _____Address:_____

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2. Medicare Beneficiaries:

Subscriber Information	**Spouse/Dependant Information**
Are you retired? No ____ Yes ____ If yes, when _____	Are you retired? No ___ Yes ____ If yes, when _____
Are you currently working? No ___ Yes _____	Are you currently working? No ____ Yes _____
Name of Employer (if applicable) _____	Name of Employer (if applicable) _____
Medicare #: _____	Medicare #: _____
Effective dates: A_____B_____	Effective dates: A_____B_____
Is your Medicare due to: Age __ Disability __ ESRD __	Is your Medicare due to: Age __ Disability __ ESRD __
If ESRD, Please give the Initial Date of Dialysis: _____	If ESRD, Please give the Initial Date of Dialysis: _____
Date of Kidney Transplant: _____	Date of Kidney Transplant: _____

Should you have any questions regarding this form please contact the Coordination of Benefits department at: 1-888-888-4742 ext. 38999 and a COB investigator will assist you.

Signature: _____ Date: _____

Harvard Pilgrim Health Care Inc.
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