Coordination of Benefits Questionnaire

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Employer Name	Group Number
Employee Name	**Employee UID**
Patient Name	**Provider Name**
Claim #	**Date(s) of Service**

Allied Benefit Systems is the claims processor for the employer group health plan ("Plan"). To enable the Plan to process the above-referenced claim, verification of Coordination of Benefits ("COB") information is required. COB is the process of determining which of two or more plans will have the primary responsibility for processing a claim, and the extent to which the other plan(s) will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one plan. If you have previously completed a similar questionnaire within the past 12 months, please disregard this form. Otherwise, please complete the questions below.

Does the patient or any family member have coverage under another plan?

☐ No. If no, please sign, date and return this questionnaire to Allied Benefit Systems.

☐ Yes. If yes, please complete all the fields pertaining to the member(s) who have other coverage

Type of Plan (Employer, Individual, Medicare, Medicaid, etc.) If Medicare, please indicate reason for entitlement:

Name of Spouse/Dependent that have other coverage	
Other Insurance Policyholder's Name	**Other Insurance Policyholder's Date of Birth**

Court Order Information
If this section is not applicable, please sign, date and return to Allied Benefit Systems.

If there is a divorce or separation, is there a court order?

No. If no, which parent has physical custody? _____

Yes. If yes, which parent is responsible for healthcare expenses? _____

_____ _____
Signature Date

Please return this questionnaire to the address shown above. Otherwise, the Plan will deny the claim. Please note the submission of the requested information does not guarantee payment, but rather allows the Plan to continue to process the claim.