



Coordination of Benefits Form

1. Do you or another family member have other health coverage? If yes, please complete all fields, sign and date.

Name of Subscriber		Address	
Date of birth	Preferred Administrators Member ID	Patient relationship to subscriber	
Name of employer group		Effective date of coverage	<input type="radio"/> Full Time <input type="radio"/> Part Time

1. Type of other coverage

<input type="checkbox"/> Other insurance <input type="checkbox"/> Retiree <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP			
Other health plan name		Effective date of coverage	
Other health plan address		<input type="radio"/> Full Time <input type="radio"/> Part Time	
Other health plan phone number	Other health plan member ID number	Is the subscriber: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> On COBRA	
Patient relationship to subscriber		Date retired	

2. If dependent is under insurance, please provide dependent information.

Name	Address
Date of birth	ID number (if not the subscriber)
Father's name and date of birth	Mother's name and date of birth

3. If separated or divorced, please provide the following:

Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical care expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify who: _____		
Who has custody of the dependent child(ren)?	Who do the child(ren) live with?	How many months of the year?

4. Do you and/or another family member have Medicare?

If yes, provide the following for each family member with Medicare.

Name of Medicare beneficiary		<input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> Both
Medicare member ID	Entitlement reason <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End stage renal disease	Effective date
If entitled due to end stage renal disease, please provide:		
The date of first dialysis	<input type="checkbox"/> Home dialysis <input type="checkbox"/> Dialysis in facility/dialysis center	Date of transplant, if applicable

You can return this form to us by mail:

Preferred Administrators (Third Party Department)
 1145 Westmoreland Drive
 El Paso, TX 79925
 Phone number 915-532-3778 Fax number 915-225-1174

Print Name of the person completing the form	
Signature	Date

NOTE: Please provide us with copies of your other insurance medical/pharmacy cards. Please don't return this form without a valid signature and date.