



Oxford Health Plans®

Coordination of Benefits Form

Please submit this form with all supporting documentation to Oxford's Coordination of Benefits Department at:

Mailing Address: P.O. Box 7071, Bridgeport, CT 06601-9630 • 800-767-3840

SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Oxford Subscriber Name: _____ Oxford ID Number: _____

Employment Information (Please check the appropriate boxes)

Actively at Work: Yes No Total number of employees at company is: 1-19 20-99 100+

Retired: Yes No Date of Retirement: ____/____/____ Spouse's Social Security Number: _____

Spouse's Name: _____ Spouse's Date of Birth: ____/____/____

Spouse's Current Employer/Company Name: _____

Spouse's Employer Address/Phone Number: _____

COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part A1, then sign and date the form.
- No other coverage, please complete Part A2, then sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, then sign and date the form.
- Medicare coverage, please complete Part C, then sign and date the form.

PART A

1. Other Coverage (list each separately)

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy #: _____ Subscriber's SS #: _____

Policy Effective Dates: Start ____/____/____ End ____/____/____ Covered Dependents: _____

Coverage Type:

(Check applicable) Hospital Major Medical Prescription Dental Retiree COBRA Other

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy #: _____ Subscriber's SS #: _____

Policy Effective Dates: Start ____/____/____ End ____/____/____ Covered Dependents: _____

Coverage Type:

(Check applicable) Hospital Major Medical Prescription Dental Retiree COBRA Other

If the other coverage is no longer in effect, you must enclose documentation from the former carrier indicating the date the policy was terminated.

2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason: Not married

Benefits not offered Unemployed Self-employed Waived, as of: ____/____/____

Part-time employee (not eligible for benefits) Waiting period, eligible for coverage on: ____/____/____

Other, please explain: _____

Please turn over

PART B

Please complete this section if you are divorced, legally separated, or a single parent, and you have dependent children covered under this plan.

1. Does the other biological parent of your dependent children provide health benefits? Yes No
 Name of other biological parent: _____ Birth date: ___/___/___

If yes, please provide the following information:

Name of other health plan: _____
 Policy #: _____
 Subscriber's SS #: _____
 Which children are covered? _____

2. Are you divorced or legally separated? Yes No Date of divorce/separation: ___/___/___
 Are you a single parent? Yes No

If divorced, check one of the following:

- Divorce decree stipulates other parent must provide health benefits
- Divorce decree stipulates joint custody
- Divorce decree does not stipulate any special provisions
- Other, please explain: _____

*A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.

PART C

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of Member eligible for Medicare: _____

Name of Member eligible for Medicare: _____

Effective Dates of Medicare:
 Part A: ___/___/___ Part B: ___/___/___

Effective Dates of Medicare:
 Part A: ___/___/___ Part B: ___/___/___

Reason for Medicare coverage
 (please check one):
 Age 65 or older
 End Stage Renal Disease (ESRD)

Reason for Medicare coverage
 (please check one):
 Age 65 or older
 End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: ___/___/___
 Disability, due to: _____

Date Dialysis Treatment Began: ___/___/___
 Disability, due to: _____

SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Print Your Name: _____

Signature: _____ Date: _____

Oxford ID Number: _____