COMMON GROUND
HEALTHCARE COOPERATIVE

Coordination of Benefits Form

Common Ground Healthcare Cooperative (CGHC) requires additional information related to Coordination of Benefits to accurately process your claims. Please complete the information below and return within seven (7) days so the processing of your claims will not be delayed.

OTHER INSURANCE:

Are you or any other member of this CGHC policy covered by another health insurance policy or any other CGHC health insurance policy?

☐ No If *No*, please complete Section D, sign, date and return this questionnaire to us.

☐ Yes If *Yes*, please complete the sections below that pertain to the member(s) that has the other health insurance coverage.

Section A: *If this does not apply or if the other coverage is Medicare, skip to Section B.*

What type of health insurance policy is this? ☐ Group ☐ Individual Policy

Who is covered by this other health insurance policy?

First Name, Last Name:	Effective date of other health insurance:
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ Yes ☐ No

List the name(s) of the dependent(s) that this applies to: _____

Other Health Insurance Carrier's Information:

Carrier Name: _____

Address, City, State, Zip: _____

Phone Number: _____

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth: ____/____/_____

Member ID Number: _____ Group Number:_____

Policyholder's Employer, if coverage is through employer: _____

Section B: *If this does not apply, skip to Section C.*

MEDICARE INFORMATION

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare: _____

Medicare Number, including alpha character(s): _____

Effective Date of Medicare Part A ____/____/_____ Effective date of Medicare Part B: ____/____/_____

Effective Date of Medicare Part D ____/____/_____

Medicare Entitlement Due to: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: ____/____/_____

1st Date of Dialysis for ESRD: ____/____/_____

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If *yes*, please provide the date of the transplant. ___/____/_____

Section C: *Signature*

Policyholder Signature: _____ Date: ____/____/_____

Please return this form to:

CGHC Claims and Correspondence
PO Box 1630
Brookfield, WI 53008-1630