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