

Coordination of Benefits Questionnaire

HMA

P.O. Box 2069 Cottonwood, AZ 86326

Phone: 800-448-3585

Fax: (866) 293-9649



FAMILY MEMBERS COVERED UNDER POLICY

Full Name	Social Security Number	Relationship To Employee	Date of Birth Mo/Day/Yr
Employee:			
Child(ren):			

Please use reverse side if additional space is needed

Name of other Insurance Carrier:	Phone Number: () -
Address:	
City, State, Zip Code:	
Full Name of policy holder:	Policy Holder Date of Birth: / /
Policy Number:	Group Name or Number:
Please check what is covered under this policy: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy	Please indicate the effective date:

If your spouse or dependents have never had any other insurance please check here:

Employee Spouse Children

If this coverage is no longer in effect you must submit a HIPPA certificate from this carrier

If additional carriers are utilized, please explain on reverse side of this form

If this coverage is for Medicare

Please check if it is coverage for Part A, Part B, or Both: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both	
Do you carry Medicare due to a disability? (please check Yes or No below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you check Yes above please explain:	
Do you carry Medicare due to end stage renal disease? (please check Yes or No below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you check Yes above please explain:	

***The above information provided will only be used to coordinate benefits.**

Signature

Date

PLEASE NOTE THAT FAILURE TO COMPLETE & RETURN THIS FORM WITHIN 45 DAYS COULD RESULT IN DELAY OR TERMINATION OF BENEFITS