Coordination of Benefits Questionnaire

Name of Facility or Provider: _____

Does the member or patient have other coverage? Yes ☐ No ☐

Other coverage type (please check option that applies):

☐ Health Insurance Effective date: ___ / ___ / _____

☐ Medicare (A___, B___, or both A & B___) Effective date: ___ / ___ / _____

Name of Patient: _____ Birth date: ___ / ___ / _____

Name of Policyholder: _____ Birth date: ___ / ___ / _____

Name of Other Insurance Company: _____

Policy Number: _____ Effective date: ___ / ___ / _____

Policyholder's Employer: _____

Policyholder's Phone Number: _____ Single Contract ☐ Family Contract ☐

Please send completed form via mail or fax to:

Mail:

AmeriHealth
P.O. Box 8240
Philadelphia, PA 19101-8240

Fax:

215-761-9176

Signature: _____ Identification number: _____
(Located on the front of the identification card)