BlueCross BlueShield of Vermont
Independent Licensees of the Blue Cross and Blue Shield Association.
www.bcbsvt.com
VERMONT Health PLAN

1-800-247-2583
1-800-535-2227 (TTY)
BCBSVT
P.O. Box 186, Montpelier, VT 05601-0186

BlueCard® Coordination Of Benefits Questionnaire

Provider: After the policy holder has completed and signed, please forward this form to Blue Cross and Blue Shield of Vermont immediately. Do not hold to submit with the claim.

Provider Information: Please complete in full	
Provider Name (Vendor):	Provider NPI (Vendor):
Provider Phone:	Date of Service:

Member Information: Please complete in full	
Policyholder Name:	Member Name:
Member ID # (including prefix):	Group Number:

SECTION I Do you or a family member have another Health Insurance policy? ▶	☐ **YES** ☐ **NO**
HEALTH INSURANCE COMPANY INFORMATION: ▼ Name:	NUMBER OF PEOPLE COVERED CHECK ONLY ONE ▼
Address:	☐ 1. ONE PERSON - POLICYHOLDER
Phone #:	☐ 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION
Policy #:	☐ 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY
Group #:	☐ 4. FAMILY – THREE OR MORE
Effective Date:	Policy Holder Name:

SECTION II Do you or a family member have a Dental Insurance policy? ▶	☐ **YES** ☐ **NO**
DENTAL INSURANCE COMPANY INFORMATION: ▼ Name:	NUMBER OF PEOPLE COVERED CHECK ONLY ONE ▼
Address:	☐ 1. ONE PERSON - POLICYHOLDER
Phone #:	☐ 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION
Policy #:	☐ 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY
Group #:	☐ 4. FAMILY – THREE OR MORE
Effective Date:	Policy Holder Name:

SECTION III Do you or a family member have Medicare Insurance? ▶		☐ **YES** ☐ **NO**
Do you have Medicare part ☐ A ☐ B ☐ D		
MEDICARE INSURANCE INFORMATION: ▼		
Policyholder Name:	Medicare Part A Effective Date:	
Medicare ID #:	Medicare Part B Effective Date:	
	Medicare Part D Effective Date:	

Form continues on other side

SECTION IV Court Order Information	
Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependents? ▶ ☐ YES ☐ NO	
List the name(s) of the dependent(s) that this applies to: ▼	
If yes, who is the person(s) listed to maintain health coverage? ▶	Who has custody of the child(ren) more than 50% of the time? ▶

Documentation of the court order may be requested from your Blue Cross and/or Blue Shield Plan

SECTION V Name(s) of Dependent(s) on Blue Cross and/or Blue Shield Policy				
Name: ▼	Relationship: ▼	Date of Birth: ▼	Gender: ▼	Social Security Number (Optional): ▼

Signature: _____ Date: _____ Phone #: _____

Dear Member,

Your Blue Cross and/or Blue shield contract may contain a Coordination of Benefits (COB) provision. Coordinating benefits ensures that members covered by more than one health or dental insurance coverage will receive all of the benefits to which they are entitled, but prevents duplicate payments. Your Plan depends upon your help in order to process you claims correctly and appreciates your prompt and accurate reply. If any of the information above changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

You have received this questionnaire because your health care provider has become aware that you have other health care or dental coverage.

Please complete the questionnaire in full, including Medicare coverage and return to your provider. The completed questionnaire will be forwarded directly to your Blue Cross and/or Blue Shield Plan. **Failure to provide your Blue Plan with current coordination of benefits information may result in the denial of future claim(s).**

We appreciate your choice of Blue Cross and Blue Shield as your health insurer.

Thank you

Reserved for member notes: