QUALCARE COORDINATION OF BENEFITS FORM

If you, your spouse, or dependent(s) have other coverage, please fill out the necessary information. If there is no other coverage, please complete Section I, IV, and VI. Accurate information is needed so that claims processing for your family will not be delayed.

Section I – Subscriber Information

Subscriber Name _____ ID#: _____

Section II - Spouse Information

Spouse's Name _____ Spouse's Date of Birth _____
Spouse's Social Security Number _____
Spouse's Current Employer/Company Name _____

Section III - Please complete the next section if you are divorced or legally separated, and you have covered dependents under this health plan. Otherwise, continue to Section IV.

Date of Divorce/Separation _____
Name of Other Biological Parent _____ Date of Birth _____
If divorced or legally separated:

- Divorce decree states other parent, _____, must provide health benefits.
- Divorce decree states joint custody with shared responsibility for medical expenses.
- Divorce decree does not state any special provisions.
- Other, please explain _____

With what parent does the child(ren) reside? _____
**A copy of the section of the court decree pertaining to health coverage would be helpful to support your response.
**You must complete Section IV with insurance information of the other parent.

Section IV - Other Coverage Information

□ **No Other Coverage** (If you had other coverage while also enrolled under your health plan administered by QualCare but that coverage ended, please enclose documentation from the former carrier stating your policy had been terminated.)

Other Insurance Name _____ Other Coverage ID# _____
Other Insurance Address/Phone Number _____
_____
Policy Effective Date _____ Policy End Date _____
Covered Members (please provide the names):
□ Subscriber _____ □ Spouse _____ □ Children _____
Is the subscriber: □ Full Time Employee □ Self-employed □ Retired, Date of Retirement: _____
Type of Coverage:
□ Hospital □ Major Medical □ Prescription □ Dental □ Vision

Section V - Medicare Coverage

Member eligible for Medicare _____
Effective Date of Part A: _____ Effective Date of Part B: _____
Reason for Medicare Coverage:
□ Age 65 or older □ Disability □ ESRD, Date Dialysis Treatment Began: _____

Section VI - Subscriber Signature

I certify that the above information is correct and complete to the best of my knowledge. I understand that I am obligated to provide this information in accordance with my plan. Failure to provide complete and accurate information may result in the delay or denial of claim payments.
Signature _____ Date _____

Please mail form to: QualCare-Cost Containment Department, 30 Knightsbridge Road, Piscataway, NJ 08854