# Medicare Advantage Coordination of Benefits Verification Questionnaire

Member Name: _____ Date: _____

Street Address: _____

City, State, ZIP Code: _____

Telephone: _____ Member ID# *(on ID card)*: _____

**In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, please complete the following Coordination of Benefits questionnaire and sign the reverse. This questionnaire helps us validate your primary health insurance. Even if you do not have other health insurance in addition to your CDPHP® Medicare Advantage plan, completing this form will prevent delays when we process your claims.**

**How to submit this form:** Visit member.cdphp.com and log in to your CDPHP member account (or register for a new one). Then select **Contact Us**, and attach the form to the **Secure Email** option. You can also mail the form to:

CDPHP
6 Wellness Way
Latham, NY 12110

1. In addition to your CDPHP Medicare Advantage health plan, will you or your spouse *(if applicable)*, have any other health insurance coverage through another CDPHP plan or another health insurance carrier?

   ◯ NO. *Please proceed to Question 2, then sign the form (on the reverse) and return it to CDPHP.*

   ◯ YES. *Please skip to Question 3 (on the reverse), then sign the form and return it to CDPHP.*

2. If you answered "NO" to Question #1 and you will not have coverage through another CDPHP plan *(other than your Medicare Advantage Plan)* or through another health insurance carrier, please provide the following information:

   Date Coverage Ended: _____

   Name of Primary Insurance Holder: _____

   Name of Employer: _____

   Size of Employer: ◯ 1–19 employees ◯ 20–99 employees ◯ 100 or more employees

   Name of Insurance Company: _____

   Insurance Company Address: _____

   Insurance Company City, State, Zip: _____

   Insurance Company Phone Number: _____

   Type of Coverage *(check and provide info for all that apply)*:

   ◯ Medical: Group Number _____ ID Number _____

   ◯ Prescription: Group Number _____ ID Number _____

   ◯ Dental: Group Number _____ ID Number _____



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3. If you answered "YES" to Question #1 and you will have coverage through another CDPHP plan (other than your Medicare Advantage Plan) or through another health insurance carrier, please provide the following information:

Name of Primary Insurance Holder: _____

Current working status of Primary Insurance Holder: ◯ Actively working

◯ Retired *(If retired, please provide the date that you retired)*: _____

Name of Employer: _____

Size of Employer: ◯ 1–19 employees ◯ 20–99 employees ◯ 100 or more employees

Name of Insurance Company: _____

Insurance Company Street Address: _____

Insurance Company City, State, Zip: _____

Insurance Company Phone Number: _____

Type of Coverage *(check and provide info for all that apply)*:

◯ Medical: Group Number _____ ID Number _____

◯ Prescription: Group Number _____ ID Number _____

◯ Dental: Group Number _____ ID Number _____

***Please contact CDPHP if any of your answers change in the future.***

***Please read the following important information, and sign and date below.***

The Coordination of Benefits Provision is part of your plan. You agree to abide by the provision through enrollment in your plan. Any person who knowingly and with intent to defraud any insurance company by filing a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Please note that references to "CDPHP" in this document refer to both Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits,® Inc. Both companies are health plans with a Medicare contract. Enrollment in CDPHP Medicare Advantage depends upon contract renewal.

Signature *(required)*: _____ Date: _____



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