



BCBS POLICYHOLDER NAME	BCBS GROUP #	BCBS MEMBER ID#
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Your Blue Cross and Blue Shield of New Mexico (BCBSNM) contract contains a Coordination of Benefits (COB) provision. If there is any other insurance, this form is required by BCBSNM in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your identification card. We appreciate your prompt reply.

OTHER INSURANCE: (PLEASE PRINT USING BLUE OR BLACK INK)

Are you or any other member of this BCBSNM policy covered by another medical or dental insurance policy or any other Blue Cross and Blue Shield policy?

NO <input type="checkbox"/>	IF NO, PLEASE MAKE ANY REVISIONS NECESSARY TO THE INFORMATION IN SECTION A, SIGN, DATE AND RETURN THIS QUESTIONNAIRE TO US, INDICATING "NO OTHER INSURANCE."	YES <input type="checkbox"/>	IF YES, PLEASE MAKE ANY REVISIONS NECESSARY TO THE INFORMATION IN SECTION A AND COMPLETE ALL THE FIELDS BELOW THAT PERTAIN TO THE MEMBER(S) THAT HAS OTHER COVERAGE.
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SECTION A				
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN (OPTIONAL)
NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN (OPTIONAL)
SIGNATURE				DATE

SECTION B (IF THIS DOES NOT APPLY, SKIP TO SECTION C)			
CHECK THOSE THAT APPLY	<input type="checkbox"/> OTHER HEALTH INSURANCE	<input type="checkbox"/> OTHER DENTAL INSURANCE	
WHAT TYPE OF POLICY IS THIS?	<input type="checkbox"/> GROUP	<input type="checkbox"/> INDIVIDUAL POLICY	<input type="checkbox"/> STUDENT POLICY <input type="checkbox"/> MEDICARE SUPPLEMENTAL
OTHER INSURANCE CARRIER'S NAME (IF MORE THAN ONE, LIST ON SEPARATE PAGE)			
ADDRESS	CITY	STATE	ZIP
DEPENDENT(S) LISTED ON THE OTHER INSURANCE		EFFECTIVE OR CANCEL DATE, IF DIFFERENT FROM POLICYHOLDER (MM/DD/YYYY)	
NAME		DATE	
NAME		DATE	
NAME		DATE	
NAME		DATE	
NAME		DATE	

OTHER INSURANCE POLICYHOLDER'S NAME			
POLICYHOLDER'S DATE OF BIRTH (MM/DD/YYYY)		IDENTIFICATION #:	
EFFECTIVE DATE OF OTHER INSURANCE		IF CANCELLED, CANCELLATION DATE	
IS THE POLICYHOLDER: <input type="checkbox"/> ACTIVELY WORKING FOR THE GROUP <input type="checkbox"/> INACTIVE			
<input type="checkbox"/> RETIRED, RETIREMENT DATE: <input type="checkbox"/> ON COBRA, WHICH BEGAN ON DATE:			
POLICYHOLDER'S EMPLOYER			
EMPLOYERS ADDRESS	CITY	STATE	ZIP

SECTION C — MEDICARE INFORMATION (IF THIS DOES NOT APPLY, SKIP TO SECTION D)

DOES THE POLICYHOLDER AND/OR DEPENDENT(S) HAVE MEDICARE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
NAME OF PERSON(S) WITH MEDICARE		MEDICARE NUMBER, INCLUDING ALPHA CHARACTER(S)	
EFFECTIVE DATE OF MEDICARE PART A (MM/DD/YYYY)		EFFECTIVE DATE OF MEDICARE PART B (MM/DD/YYYY)	
EFFECTIVE DATE OF MEDICARE PART C (MM/DD/YYYY)		EFFECTIVE DATE OF MEDICARE PART D (MM/DD/YYYY)	
MEDICARE ENTITLEMENT	<input type="checkbox"/> AGE	<input type="checkbox"/> DISABILITY*	<input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)*
*IF THE REASON IS FOR DISABILITY OR ESRD, PLEASE PROVIDE THE FOLLOWING:			
1ST DATE OF DISABILITY		WAS ESRD STARTED AS SELF DIALYSIS OR HOME DIALYSIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
1ST DATE OF DIALYSIS FOR ESRD		HAS A TRANSPLANT BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
1ST DATE OF DISABILITY		WAS ESRD STARTED AS SELF DIALYSIS OR HOME DIALYSIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WAS ESRD STARTED IN A FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE PROVIDE THE DATE OF THE TRANSPLANT	
IN ADDITION, PLEASE PROVIDE A COPY OF THE MEDICARE CARD			

SECTION D — COURT ORDER INFORMATION

IS THERE A COURT ORDER SPECIFYING A PERSON(S) WHO MUST MAINTAIN HEALTH COVERAGE FOR ANY OF YOUR DEPENDENT(S)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
LIST THE NAME(S) OF THE DEPENDENT(S) TO WHOM THE COURT ORDER APPLIES:	
IF YES, WHO IS THE PERSON(S) LISTED TO MAINTAIN HEALTH COVERAGE?	
WHAT IS THE RELATION TO THE CHILD(REN)?	
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 BLUE SHIELD PLAN.	