(DT-R 561)

Avera Health Plans

Coordination of Benefits
Request for Information Form

Your Avera Health Plans health insurance contains a Coordination of Benefits provision which applies to situations where there may be overlapping coverage for you or your dependents. This form is used for the sole purpose of gathering information about other health care carriers who provide health benefit coverage for you and/or your dependent(s).

IMPORTANT NOTE: This form must be completed and mailed to us within 10 business days to ensure accurate and timely processing of your claims.

Are you, your spouse or any of your dependents who are covered by us, also covered by another health insurance policy?

____ No If No, please complete Section 1 and mail this form to us.

____ Yes If Yes, please complete all the applicable sections beginning with Section 1 and mail this form to us.

SECTION 1. AVERA HEALTH PLANS SUBSCRIBER INFORMATION (Please print.)

Subscriber Name:_____ Subscriber Number: _____

Subscriber Mailing Address: _____

City:_____ State:_____ ZIP Code: _____

I certify that the information furnished by me on this form is true and correct at this time and agree to inform Avera Health Plans of any changes.

Subscriber Signature:_____ Date: _____

SECTION 2. SPOUSE INFORMATION (If not married, skip to Section 3.)

Spouse's Name:_____

Spouse's Date of Birth: _____

Spouse's Current Employer, Company Name: _____

Spouse's Social Security Number: _____

SECTION 3. OTHER COVERAGE INFORMATION

Other Insurance Name:_____ Other Insurance Member ID Number: _____

Other Insurance Phone Number:_____ Type of Policy: ____ Group Policy ____ Individual Policy

Policy Effective Date:_____ Policy End Date: _____

Policyholder's Name:_____ Policyholder's Date of Birth: _____

Policyholder's Employer Name: _____

If group policy, is the policyholder:

____ Full-Time Employee

____ Covered Through COBRA

____ Retired / Date of Retirement:_____

Covered Benefits:

____ Medical

____ Dental

____ Vision

____ Pharmacy

Name(s) of covered dependent(s) with dual coverage:

_____

_____

_____

Relationship to Policyholder:

_____

_____

_____

Please continue to the second page of this form.

SECTION 4: ADDITIONAL INFORMATION

If you are divorced or legally separated from the policyholder in Section 3 and you have covered dependents with us, complete Section 4. (If not, proceed to Section 5.)

Date of divorce or legal separation: _____

Other Biological Parent's Name: _____ Other Biological Parent's Date of Birth: _____

Name of person who has been awarded legal custody of the child(ren): _____

Name(s) of covered dependent(s)

_____

_____

_____

Select One*:

____ Divorce decree states _____ must provide health insurance.
(Insert name here)

____ Divorce decree does not state any special provisions pertaining to health insurance.

____ Other, please explain _____

**A copy of the section of your court decree pertaining to health insurance or other documents must be provided to support your response.*

SECTION 5. MEDICARE COVERAGE INFORMATION

Do you or any of your dependents on this policy also have Medicare coverage?

____ Yes, complete the following for those on Medicare

____ No, you are done. Please mail completed form to Avera Health Plans.

If more than one family member has Medicare coverage, please submit a form for each covered member.

Member Eligible for Medicare: _____ Medicare Number: _____

Effective Date of Part A: _____ End Date of Part A: _____

Effective Date of Part B: _____ End Date of Part B: _____

Effective Date of Part D: _____ End Date of Part D: _____

Reason for Medicare Coverage:

____ Age 65 or older

____ Disability, date disability began: _____ Date disability ended: _____

____ End-Stage Renal Disease, date dialysis treatment began: _____

Mail to Avera Health Plans, Attn: Coordination of Benefits, 5300 S Broadband Ln, Sioux Falls, SD 57108-2221
Our Customer Care Team is available Monday through Friday at 605-322-4545 or toll-free at 888-322-2115