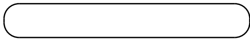
Coordination of Benefits Form



Please complete the information below. If you have any questions regarding this form, please contact Customer Service at the number on the participant's medical card.

Your policy contains a "coordination of benefits" provision that allows Evernorth Behavioral Health to share responsibility in covering health care expenses with any other company covering you or your family for medical benefits. When health care expenses are shared between two or more companies, out-of-pocket expenses for the participant may be reduced. In addition to benefiting the individual member, coordination of benefits is beneficial to all participants because it avoids duplication of payments that would result in higher premium rates.

Coordination of Benefits

Employee: ______________________ Date of Birth: __________

Employer Name: ______________________ Account Name: ______________________

Social Security Number (SSN): ______________________

Patient Name: ______________________ Participant Date of Birth: __________

Address: ______________________

City: ______________ State: ____ Zip Code: ________

If married complete the following:

Employee Spouse's Name : ______________________ Date of Birth: __________

Spouse's Employer Name: ______________________

Spouse's Address: ______________________

City: ______________ State: ____ Zip Code: ________

Is spouse covered under his/her employer's health plan? ☐ Yes ☐ No *If yes, please complete the following:*

Employer's health plan name: ______________________

Address for submitting claims: ______________________

City: ______________ State: ____ Zip Code: ________

Policy Number: ______________ Effective Date: __________ ☐ Single Coverage ☐ Family Coverage

If family coverage, list all covered members:

____

If you are divorced and/or remarried with dependents, please complete the following:

Dependents	Person with Physical Custody	Relationship	Person Responsible for Dependent Health care Expenses per Divorce Decree

If you or your family members are covered under any other medical/dental plan in addition to the coverage listed above (i.e., Medicare or Medicaid, other insurance), please complete the following section. (This does not include the employee's current insurance plan.)

Health Plan Name	Name of Person Covered	Policy Number	Effective Date

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Coordination of Benefits *(cont'd)*

I certify the above information is true and correct. I understand that the purpose of this information is to assure appropriate coordination of benefits of all plans.

Signature of Participant **Date**

MAIL TO:
Evernorth Behavioral Health
PO Box 188020
Chattanooga, TN 37422

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