network health

COORDINATION OF BENEFITS QUESTIONNAIRE

You can update your coordination of benefits information by calling Network Health's Member Experience Department at 800-826-0940, Monday–Friday from 8 a.m. to 5 p.m. Or, fax the completed form to 920-720-1910.

SECTION 1 YOUR NETWORK HEALTH INFORMATION

Network Health member/participant name (as found on your ID card)	Network Health member/participant ID number

In addition to this Network Health contract, are you or any of your covered dependents also covered by another group health care plan? If other insurance coverage is due to divorce, separation or court order please complete section 3. If you have additional Network Health contracts, please include this as other coverage.

❑ NO – Please skip the rest of the questions, sign at the bottom and return.

❑ YES – Please complete the entire form, sign at the bottom and return.

SECTION 2 OTHER HEALTH COVERAGE INFORMATION

Please provide the following information about the policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Employer		Date of birth
Insurance company name	**Insurance company address**	**City**	**State**	**Zip code**
Member/participant ID/policy number	**Group number**	**Effective date**	**Cancellation date (if applicable)**	

Type of coverage	Is this a COBRA contract?	Type of plan
❑ Single ❑ Family	❑ Yes ❑ No	❑ Medical
	Is the policy holder laid off? ❑ Yes ❑ No	(Check all that apply) ❑ Drugs ❑ Dental

Who is covered by this other plan? Include yourself if applicable.

	Name (first and last)	Relationship to you	Social Security Number*
1.			
2.			
3.			
4.			
5.			

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation or court order. If not applicable skip the rest of the questions, sign at the bottom and return.

Is there a court order that determines responsibility for health care coverage or custody? ❑ No ❑ Yes

Name of person responsible for child's health care coverage	Social Security Number*	Employer		Date of birth
Insurance company name	**Insurance company address**	**City**	**State**	**Zip code**
Member/participant ID/policy number	**Group number**	**Effective date**	**Cancellation date (if applicable)**	

Which children are covered by this insurance?

Child's name (first and last)	Who has custody?	Child's name (first and last)	Who has custody?
1.		4.	
2.		5.	
3.		6.	

* Social Security Numbers are not used for member identification. This is a CMS requirement for coordination of benefits administration.

Subscriber's signature _____ **Date** _____

Return completed forms to: **Network Health**
Coordination of Benefits
P.O. Box 120
Menasha, WI 54952

For Network Health Use

Claim Number: _____