

## COORDINATION OF BENEFITS QUESTIONNAIRE

**It is important that you complete and return this survey.** Coordination of benefits is a way to coordinate benefit payments when you or your dependents are covered by a health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Are you, your spouse, or any of your dependents covered by a health plan, Medicaid or Medicare?  Yes  No

- If yes:**
- For health insurance and Medicaid plans, please complete sections 1 & 2.
  - For Medicare coverage only, please complete sections 1 & 3.
  - For other health insurance plans and Medicare, complete sections 1, 2 & 3.
- If no:** - Please complete section 1 and sign your name.

**PLEASE PRINT**

SECTION 1—TO BE COMPLETED BY ALL TRIBAL MEMBERS			
Tribal Members' Name	Birth Date	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	State for Medicaid coverage
Tribal Members' Roll Number	Phone Number Where You May Be Reached	Today's Date	
SECTION 2—OTHER COVERAGE INFORMATION			
Name of Policyholder	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Relationship to You
Name of Health Plan		Policyholder Identification Number	
Health Plan's Address		Phone Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employer's Name		
<b>Type of Coverage</b>	<input type="checkbox"/> Medical	<input type="checkbox"/> Rx	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
Effective Date	_____	_____	_____
Cancellation Date	_____	_____	_____
<b>Please list any other dependents covered by this plan. If there are more than four, please check this box <input type="checkbox"/> and list the rest on the back of this form.</b>			
1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You
SECTION 3—MEDICARE COVERAGE INFORMATION			
Name of Medicare Beneficiary			
Medicare Number _____	<b>Type of Coverage</b> Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	<b>Medicare Eligibility Due to:</b> <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date _____	
<b>MAIL FORM TO: HEALTH &amp; SOCIAL SERVICES 10100 S. BLUEJACKET RD., STE. 1, WYANDOTTE OK 74370</b>			