Benefits Administration
Post Office Box 619031
Roseville, CA 95661-9031
800-441-2524
AdventistHealth.org

Coordination of Benefits

Other insurance/health coverage form

For enrollees of the Adventist Health Employee Medical, Dental, and Vision Plans

You are required to respond to this form. The purpose of this form is to collect information about the other insurance/health coverage you and your dependents currently have, or have had in the last two years, so that we may process your claims accurately. If you and your dependents have not had other insurance/health coverage within the last two years, then you must so indicate.

Please complete and return this form **no later than 31 days from the date of this letter or all claims submitted after 31 days from the date of this letter will be denied.**

Adventist Health Employee Health Plan subscriber information

Subscriber Name	ID Number	Subscriber Phone Number

Other insurance/health coverage information

Do you or one of your dependents (including your spouse) who are covered under the Adventist Health Employee Medical, Dental, or Visions Plans currently have other medical, dental, and/or vision coverage, or have had such other coverage within the last two years?

☐ **Yes** - Complete all applicable fields, and sign, date and return this form.

☐ **No** - Please sign, date, and return this form confirming that you and/or your covered dependents (including your spouse) have not had any other medical, dental, and/or or vision coverage in the last two years.

Other insurance/health coverage subscriber information

(If you answered **yes** above, fill in the information below about the person who has the other insurance/health coverage.)

Name	Date of Birth (DOB) (mm/dd/year)	Other medical coverage (Y/N)	Other dental coverage (Y/N)	Other vision coverage (Y/N)	Indicate whether this person is the ***dependent*** or ***spouse*** of the primary subscriber/policy holder under the other insurance/health coverage. If person is primary, state ***primary.***

Other insurance/health coverage subscriber information

Subscriber name:	Subscriber DOB:
Effective Date*:	Termination Date*:
Other Insurer/Plan name*:	

***Indicates required field** **Please attach additional pages, if necessary.**

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If legally separated or divorced from the subscriber of the other insurance/health coverage, please provide the following:

Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental or other health care expenses? ☐ Yes – Specify who: _____ ☐ No		
Who has custody of the dependent child(ren)?	Who do the child(ren) live with?	How many months of the year?

Medicare: Please complete if you or any of your dependents have Medicare

Name of Medicare beneficiary		Circle one Medicare A Medicare B Both
Medicare member ID	Entitlement reason Age Disability End stage renal disease	Effective date
If entitled due to end stage renal disease, please provide:		
The date of first dialysis:	☐ Home dialysis ☐ Dialysis in facility/dialysis center	Date of transplant, if applicable

Return this form within 31 days of the date at the top of this letter to one of the following:

Email: eligibility@ah.org
Fax: 916-406-1780
Mail: Benefits Administration
PO Box 619031
Roseville, CA 95661-6031

Signature required:

I hereby verify that the above information is accurate to the best of knowledge.

Name (print): _____

Signature: _____ Date: _____