Coordination of Benefits (COB) Form

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Many patients have more than one health insurance policy. In order for us to properly bill your insurance companies and ensure claims are paid correctly, we need accurate and current information regarding all coverage you or your child may have. This form allows us to coordinate benefits between policies and bill in the correct order.

Primary Insurance Information

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy/Member ID: _____

Group Number: _____

Relationship to Patient: _____

Secondary Insurance Information

Does the patient have a second active insurance policy?

☐ Yes ☐ No

If yes, please complete the following:

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy/Member ID: _____

Group Number: _____

Relationship to Patient: _____

Other Coordination Information

Is the patient covered under any additional insurance policies?

[ ] Yes [ ] No

If yes, please complete the following:

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy/Member ID: _____

Group Number: _____

Relationship to Patient: _____

Is the patient covered under Medicaid or a state program?

☐ Yes ☐ No

If yes, Medicaid number: _____

Consent and Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that:

Failure to provide accurate or updated insurance information may result in denied claims and patient responsibility for charges.

Signature of Patient/Parent/Guardian: _____

Printed Name: _____

Date: _____