



866-815-6001
 855-613-4102
 detegohealth.com
 759 N 114th Street # 300, Omaha, NE 68154

Member Name: _____
 Member ID: _____

COORDINATION OF BENEFITS FORM

For the fastest processing, log into your **online portal** account; the Coordination of Benefits form can be found in the *Action Items* section.

Section 1 – Member Insurance Information

Are you, your spouse or dependent children covered by any other medical and/or dental coverage?

<input type="checkbox"/> No, Detego Health (Complete Section 7)	<input type="checkbox"/> Yes, other insurance (Complete Sections 2-5 & 7)	<input type="checkbox"/> Yes, Medicare (Complete Sections 6 & 7)	<input type="checkbox"/> Yes, Medicaid or CHAMPUS/VA (Complete Section 7)
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Section 2 – Other Insurance Information

Please list all applicable health and/or dental insurance carriers in the space provided. Attach another sheet if needed.

Insurance Company Name	Insurance Company	Type of Coverage (select all that apply)	Type of Enrollment (select one)	Other Insurance Effective Date (mm/dd/yyyy)	Other Insurance Status (select one)
		<input type="checkbox"/> Medical/Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Dental	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child		<input type="checkbox"/> Active <input type="checkbox"/> Reserves <input type="checkbox"/> Retiree

Section 3 - Policyholder Information for Other Insurance

Policyholder on the policy indicated in section 2:

Last Name:	First Name:
Identification Number (include all letters and numbers):	Policyholder DOB:
Employer Name, if applicable:	
Relationship to policyholder listed at the top: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Ex or legally separated spouse <input type="checkbox"/> Other	
If relationship is "Self" or "Spouse", indicate employment status: <input type="checkbox"/> Actively working with employer offering other coverage <input type="checkbox"/> Not actively working/ long-term disability <input type="checkbox"/> Retired from employer providing other coverage Retirement date _____ <input type="checkbox"/> On COBRA COBRA effective date _____	

Section 4 - Covered Persons

Complete the following information for all persons covered under the other policy. Attach a separate sheet if needed.

Covered Person First and Last Name	Relationship to the policyholder in Section 3 (i.e. self, spouse, child, step-child, custodial parent)	Date of Birth (mm/dd/yyyy)	Mark if covered by Medicare or Medicaid	Mark if dependents are covered under court order
1.			<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>

Section 5 - Parents that are Divorced, Legally Separated or Never Married

Only complete this section if dependent children are covered under the other policy and the parents are divorced, legally separated or were never married.

If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the court order.	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Joint Responsibility	<input type="checkbox"/> Legal Guardian
If there is no legally binding agreement for health care expense, who has primary custody?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Joint Legal Custody	<input type="checkbox"/> Legal Guardian

Section 6 - Medicare Enrollee Information

Beneficiary Name	Medicare ID	Employment Status	Coverage Type	Effective Date (mm/dd/yyyy)	Medicare Entitlement Reason
		<input type="checkbox"/> Employed <input type="checkbox"/> Retired Date: _____	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	_____ _____ _____	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD
		<input type="checkbox"/> Employed <input type="checkbox"/> Retired Date: _____	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	_____ _____ _____	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD

Section 7 - Policyholder Signature

 Signature _____ Date

Daytime Phone Number: _____



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Instructions for Coordination of Benefit Form

Coordination of Benefits (COB) applies when more than one insurance company provides you and/or your family members with health care benefits. COB is applicable to you and all family members that are covered under your current health and/or dental plans.

The following instructions can be used to assist you in filling out the attached COB form. Complete and submit the attached hard copy, which can be mailed or faxed back to us.

Mail to:
Detego Health
759 N 114th St #300
Omaha, NE 68154
Fax: 855-613-4102

Section 1 – Member Insurance Information:

If you or any of your dependents are not covered under another health or dental plan, answer No and skip to Section 7. Please sign and date and provide a daytime phone number so we can contact you if we have any questions. Your form will need to be returned to us at the address or fax number above.

If you or any of your dependents are covered under another health or dental plan, please select Yes to all other answers that apply.

If you answered “Yes, complete Sections 2 – 5, and 7. If you answered “Yes, Medicare,” you will need to complete Sections 6 and 7.

If you answered “Yes, Medicaid or CHAMPUS/VA,” you only need to complete Section 7.

Section 2 – Other Insurance Information:

You only need to complete this section if you answered “**Yes, other insurance**” in Section 1. Please provide the name and phone number of the other health and/or dental companies that cover you and/or your dependents. Indicate the type of coverage, type of enrollment and effective date. Please select all that apply to you and your family.

If you have coverage with more than two other insurance companies, please attach a sheet including all the information indicated.

Section 3 – Policyholder Information of Other Insurance:

Complete this section if you answered “**Yes, other insurance**” in Section 1. This information pertains to the additional insurance coverage you or your dependents have with another insurance company (as indicated in Section 2).

Please provide the policyholder’s first and last name, identification number of the other insurance, date of birth, and employer, if applicable. Select the relationship to the policyholder and their employment status.

For example, if your spouse has additional coverage through their employer, your spouse would be the policy holder; their relationship to you would be spouse. In this example, they would mark "Actively working with employer offering other coverage."

Section 4 – Covered Persons

Complete this section if you answered “Yes, **other insurance**” in Section 1. “Covered persons” refers to all individuals covered under the other plan and your Detego Health plan. Please attached a second sheet if needed.

Section 5 – Parents that are Divorced, Legally Separated or Never Married

Complete this section if you answered “Yes, **other insurance**” in Section 1. Only complete this section if dependent children are covered under both your Detego Health policy and the other policy, and the parents are divorced, legally separated or never married. Please answer the questions provided on the form and include the legal documentation, if applicable, when return the COB form.

Section 6 – Medicare Enrollee Information

Complete this section if you answered “Yes, Medicare” in Section 1. The beneficiary, Medicare ID, coverage type and effective date information can be found your Medicare identification card. Please answer all questions that apply.