



Capital Health P L A N

Dear Subscriber:

The responsibility of Capital Health Plan's Other Party Liability Department is to assist in the smooth financial operation of the Plan and to do everything we can to try to keep your rates as low as possible.

In an effort to achieve this task we are asking for your help! Capital Health Plan may be entitled to recover some of its expenses when providing patient care services to a member who is covered by another group insurance, for example, a spouse covered through their employer. This prevailing industry practice is known as "Coordination of Benefits" (COB) and allows the carrier who is "primary" to pay for most of the costs of services. The process of accurately coordinating benefits between more than one insurance plan enables Capital Health Plan to ensure that claims are processed in both a timely and efficient manner.

In no event shall the recovery of expenses from an alternate carrier result in the member paying for any of these services covered by Capital Health Plan. It simply allows us to coordinate with the carrier who is legally responsible and use this recovery to help keep our premiums as low as possible. Also, no "Coordination of Benefits" will be pursued against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplemental policy.

Please take a minute to complete the enclosed Coordination of Benefits questionnaire and return it to the Other Party Liability Department.

Capital Health Plan values your membership and will continue to provide the quality service and care that you deserve.

If you have any questions about COB, please feel free to call us at 850-383-3458.
Your cooperation in this effort is greatly appreciated.

Sincerely,

Frank Kaminski
OPL Representative
OPL Department

Enclosures



Capital Health
P L A N

We Need Your Help With "COB"

Coordination of Benefits, or "COB", as it is commonly called, is important to you and to Capital Health Plan, even though it may be a phrase with which you are not familiar. Coordination of Benefits is a provision in group health insurance contracts that prevents duplicate payments for the same covered expense. We'd like to explain to you how COB works, why it is important and how you can help our COB process.

Health insurance, as you know, exists to protect the subscriber from costly health care expenses. It is not intended to be a means of making profit. To profit from an illness or injury would destroy the value of cost containment and the principle of health insurance itself.

The Coordination of Benefits provision in a health care program comes into play only when a subscriber is covered under more than one group health insurance program. In many families today, both husband and wife work. She has a family health insurance program through her employer, and he has family coverage through his employer. The COB provision prevents duplicate payments for the same covered expense, thus helping to keep down the cost of health care.

When coverage by two insurance groups is involved, one carrier is always the "primary" carrier, and responsible for paying the full benefits under its contract. The other carrier, known as the secondary carrier, is responsible for paying any allowable expenses not paid by the primary carrier up to a maximum of its contract obligations, but not more than the total covered expenses incurred by the subscriber.

How does COB work? Before benefits are paid, we must know who the primary carrier is. Standard rules have been established to decide the "primary" carrier. Capital Health Plan includes a COB provision in its contract and we abide by these standards. They are as follows:

- If one of the group carriers does not include a COB provision in its contract and the other one does, the group carrier without a COB provision is always primary and will pay benefits first, up to the full extent of its obligation.
- If both group carriers provide for COB in their contract and the subscriber belongs to two health care programs, the group carrier which the individual has been enrolled with for the longest time will be the primary carrier.

- If a husband and wife have group health programs through separate carriers, each with COB provisions and each providing coverage for a "spouse and family", the primary carrier is determined as follows:
 1. The husband's carrier will be primary when he receives health services and the wife's will be secondary.
 2. When the wife incurs health care expenses, her carrier will be primary and the husband's will be secondary.
 3. When a dependent child in the family incurs health care expenses, the carrier covering the parent whose birthday occurs earlier in the calendar year is primary.

By identifying primary and secondary group carriers and determining which insurer pays first, COB helps to contain rising health care costs, thereby benefiting all members.

This may be confusing, but if both coverages are used when appropriate, everyone benefits because in the end it helps keep everyone's health care costs down by placing the payment responsibility in the proper place.

We are asking your help in completing our COB file. Please fill out the enclosed COB questionnaire and mail it to us, even though you may have filled out such a form in the past. In addition, we ask that you keep us informed if your other group carrier coverage should change, that is, if you switch companies. You may notify us of any changes by calling **383-3300** and ask for the Other Party Liability Department.





COORDINATION OF BENEFITS QUESTIONNAIRE

Member's Name _____ Member's CHP ID# _____

We need your help to assure that the information we have in our system is current. Please complete the following form and return the form in the enclosed self-addressed envelope.

Do you or any individual under this contract have any other (group) health insurance.

- Yes—If answer is yes, please complete the following information and sign below.
- No—If answer is no, please sign form and return.

OTHER INSURANCE INFORMATION

1. Name of policyholder who has the other group health insurance policy. If Medicare only, skip to Section 2.

Last	First	Birth date	Relationship to you	Social Security Number
_____	_____	____/____/____	_____	____/____/____

Name and Telephone Number of Other Policyholder's Employer

Other Insurance Carrier Information

Name: _____
 Address: _____
 Telephone Number(s) _____

Coverage Type – Please check all that apply.

- | | | |
|--|--|---------------------------------|
| <input type="checkbox"/> Managed Care Plan | <input type="checkbox"/> Major Medical | |
| <input type="checkbox"/> Rx | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Supplemental | <input type="checkbox"/> Cancer | |

Policy No.	Group No.	Effective Date
_____	_____	____/____/____

(a) List the names of your family members who are covered by the policy indicated above. If coverage is a result of divorce/separation also fill out Section b.

Last	First	Last	First
_____	_____	_____	_____
_____	_____	_____	_____

(b) List any family member covered by additional group health insurance resulting from a divorce/separation.

Name of child	Parent with Primary Custody	Is there a Court Order for payment of child's health care expenses?	If YES, Parent with Primary Responsibility	Name of Insurance Carrier
Last	First			
_____	_____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> No <input type="checkbox"/> Yes (Attach Copy)	_____	_____
_____	_____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> No <input type="checkbox"/> Yes (Attach Copy)	_____	_____

MEDICARE INFORMATION

2. List any family member who is eligible for Medicare Benefits.

Name of family member	Medicare Number	Part A Effective Date	Part B Effective Date	Actively Employed?
Last	First			
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> No. <input type="checkbox"/> Yes
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> No. <input type="checkbox"/> Yes

I certify that the above information is true and correct and authorize any group insurance carrier, employer, hospital or doctor to furnish or obtain from Capital Health Plan any information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other group health insurance plan providing benefits to which I may be entitled. In the event that any bills are paid by Capital Health Plan, which should have been paid by any other primary carrier, I authorize reimbursement of these expenses directly to Capital Health Plan.

Member's Name Printed	Member's Signature	Date
_____	_____	_____

Work Phone No.	Home Phone No.
_____	_____

Your cooperation in providing the above information is greatly appreciated. If you have any questions, please contact an Other Party Representative at (850) 383-3458.



Capital Health
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- 2140 Centerville Place • Tallahassee, Florida 32308 • P.O. Box 15349 Tallahassee, Florida 32317-5349
- Telephone (850)383-3300

Authorization to Disclose Protected Health Information

Member Name: _____
Last First Middle (Maiden)

Member's Date of Birth: _____ **Last Four Digits of SSN#** _____ **Phone Number:** _____
Member's ID Number: _____

REQUEST COPIES OF MY RECORDS

FROM:
Name (Releaser) CAPITAL HEALTH PLAN

Address P.O. BOX 15349

City TALLAHASSEE State FLORIDA Zip 32317

RELEASE COPIES OF MY MEDICAL RECORDS

TO: LIST OTHER INSURANCE COMPANY
Name (Releasee) _____

Address _____

City _____ State _____ Zip _____

TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: (Include dates where appropriate) FROM: (Date) _____ **TO: (Date)** _____

- | | | | |
|---|---|--|-----------------------------------|
| <input checked="" type="checkbox"/> Billing/Financial Information | <input type="checkbox"/> Lab results | <input type="checkbox"/> Problem List | <input type="checkbox"/> Eye Care |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Medication List | <input type="checkbox"/> X-ray/Imaging | |
| <input type="checkbox"/> Complete CHP record | <input type="checkbox"/> Mental Health/Counseling | <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Enrollment/Disenrollment | <input type="checkbox"/> Other: _____ | |

PURPOSE OF DISCLOSURE: Continued Medical Care Changing PCP & discontinuing care at this office
 Leaving town & transferring records to new physician Attorney Personal Reasons
 Insurance Office of Disability Determination Worker's Compensation Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse. I agree to such release **Initial and Date:** _____

I understand that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire in **six (6)** months from the date signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in **CFR 164.524**. If I have questions about disclosure of my health information I can contact a Medical Records Supervisor, Member Services or the Privacy Officer.

Signature of patient or legal representative _____ **Relationship** _____ **Date** _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (FL395.017, 455.241 and 394.459) and federal law 42 CFR, part II.

Requestor Verified **How Verified:** _____ **Completed by:** _____