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.

<u>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</u>. 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 pursed 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 at the following address: Capital Health Plan, P.O. Box 15349, Tallahassee, FL 32317-9940- Attention OPL 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 850-383-3311.
Your cooperation in this effort is greatly appreciated.

Sincerely,

Other Party Liability Department
Capital Health Plan

2011.05.001

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 form and return to the following address: **Capital Health Plan, P.O. Box 15349, Tallahassee, FL 32317-9940**

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

☐ Yes—If answer is yes, please complete the following information.
☐ 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 Phone Number of Other Policyholder's Employer
____
____

Other Insurance Carrier Information
Name: ____
Address____
Phone ____

Coverage Type – Please check all that apply.

_ Managed Care _Major Medical _Supplemental

_ Rx _Dental _Cancer _Vision

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 Last	First	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
______________	______________	☐ Mother ☐ Father ☐ Joint	☐ No ☐ Yes (Attach Copy)	______________	______________
______________	______________	☐ Mother ☐ Father ☐ Joint	☐ No ☐ Yes (Attach Copy)	______________	______________

MEDICARE INFORMATION

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

Name of family member Last	First	Medicare Number	Part A Effective Date	Part B Effective Date	Actively Employed?
______________	______________	______________	____/____/____	____/____/____	☐ No. ☐ Yes
______________	______________	______________	____/____/____	____/____/____	☐ No. ☐ 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 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) 383-3311.

Rev 03/11
2011.05.002