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

Your cooperation in this effort is greatly appreciated. If you have any questions about COB, please feel free to call us at 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1- March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1- September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

Sincerely,
Other Party Liability Department

Capital Health Plan Advantage Plus (HMO), Preferred Advantage (HMO) and Retiree Advantage (HMO) are HMO plans with a Medicare contract. Enrollment in Capital Health Plan Advantage Plus, Preferred Advantage and Retiree Advantage depends on contract renewal**.** Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. (Español (Spanish)) Capital Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.(Kreyòl Ayisyen (French Creole)) Capital Health Plan konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

2019.4.18/ 2017.11.28 / 2016.10.17 / 2013.11.009

COORDINATION OF BENEFITS QUESTIONNAIRE

Policyholder's Name _____ Policyholder'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, Attn: OPL Dept., P.O. Box 15349, Tallahassee, FL 32317-9940**

Do YOU or any Person Covered under YOUR CHP Policy have any other 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 Health Insurance policy. **If Medicare only, skip to Section 2.**

Last	First	Birth date	Relationship to you
_____	_____	____/____/____	_____

Name and Phone Number of Other Policyholder's Employer:

_____

_____

Other Insurance Carrier Information

Name: _____
Address: _____
Phone: _____

Coverage is as: ☐ Active employee ☐ Retiree (Date Retired: _____) ☐ COBRA

Coverage Type – Please check all that apply
☐ Managed Care ☐ Major Medical

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.

_____	_____	_____	_____
Policyholder's Signature	Date	Work Phone No.	Home Phone No.

If you have any questions, please contact an Other Party Representative at (850) 383-3419.

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