



259 Monroe Avenue, Rochester, NY 14607
www.preferredcare.org

SYSDATE

COORDINATION OF BENEFITS INFORMATION FORM

Dear Head of Household:

Case Number: *ALT KEY*

To ensure prompt payment of your health care claims, we need this information for each member listed on your case. Please return this form in the enclosed postage paid envelope. Use a separate sheet of paper if more room is needed.

Your name: *FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C*

Address: *ADDRESS-1
ADDRESS-2
CITY;;; STATE; ZIP*

Phone number: *PHONE1*

Preferred Care Option ID Numbers (CIN): _____

1. Are you or any Preferred Care Option member(s) in your household covered by another health insurance besides Medicaid? YES _____ NO _____

If NO, please continue to #2. If YES, please complete the following information for each person with other insurance.

Name of member(s) with other insurance: _____

Date of Birth: _____ SS#: _____ Employer: _____

Name & Address of Other Insurance: _____

Contract # and Effective Date: _____

Single, Two-person or Family Coverage: _____

Hospital, Medical, Surgical, or Other Coverage: _____

2. Are you or any Preferred Care Option member(s) in your household covered by No-Fault (auto), Workers Compensation, or other liability insurance due to an accident, illness, or injury?

YES _____ NO _____

If **NO**, please continue to #3. If **YES**, please complete the following information for each person with other insurance.

Name of member(s) covered as described above: _____

Date of Birth: _____ SS#: _____ Employer: _____

Type of Other Insurance: Workers Comp _____ No-Fault _____ Other _____

Name & Address of Other Insurance: _____

Date of injury/illness/accident: _____ Claim/Case# _____

Describe injury/illness/accident: _____

3. Are you or any Preferred Care Option member(s) in your household covered by Medicare?

YES _____ NO _____

If **NO**, please sign at bottom and return. If **YES**, please complete the following:

Name of member(s) with Medicare coverage: _____

Medicare ID#: _____

Effective Date Part A: _____

Effective Date Part B: _____

Reason(s) for Medicare Coverage: _____ Age 65 or older & actively employed
_____ Age 65 or older & retired
_____ End Stage Renal Disease
_____ Disability

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars.

Head of Household Signature

Date