Health Care ID #:

Name: **Patient Name:**

Address: **Claim#:**

City: **ST:** **Zip:**

In order to process your claims (Medical, Dental or Vision), your employer-sponsored health plan requires a completed Coordination of Benefits (COB) questionnaire. The information collected is used to ensure that your providers are paid appropriately and that you and your covered dependents receive all the benefits of your health plan.

To prevent denial of your claims after 90 days from the date of this letter, please contact Delta Health Systems by calling the number on the back of your identification card. We can accept your COB information over the phone.

You may also:

- complete and email the COB questionnaire to special.project1@delapro.com,
- log into www.deltahealthsystems.com and complete the form online,
- mail the COB questionnaire to P.O. Box 648 Stockton, CA 95201-0648, **AND**
- if applicable, provide a copy of the front and back of the insurance card from your other carrier. *Note: If you or your dependent has Medicare coverage, please submit copies of your Medicare cards*.
- if applicable provide a copy of the front and back of any court orders. All pages must be provided.

Section 1: Other Coverage

Have you or any of your dependents had any other health insurance coverage in the last year? ☐ Yes ☐ No

If **yes**, please complete Section 2 and sign Section 3. If **no**, please sign Section 3.

Section 2: Complete this section if only your dependents have coverage other than the plan they are currently enrolled in. The below is information necessary to Coordinate Benefits.

Other Medical Plan Information (if no Medical, answer questions below for Dental and Vision coverage)

Telephone Number:

Name of Plan:

Group Policy #:

Effective Date of Coverage:

Policyholder ID #:

Coverage Termination Date:

Date of Birth (MM/DD/YYYY):

Policyholder's Name:

Active: Retiree:

Name of Employer:

Type of Coverage: Check all that apply.

☐ **Medical** ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Other

☐ Medicare ☐ Medicaid/Medi-cal ☐ **Dental** ☐ **Vision** ☐ Prescription Drug

Complete for Covered Dependents *if* any of your dependents have medical, dental, or vision coverage.

Name(s)	Relationship	Date of Birth (MM/DD/YYYY)	If there is a qualified medical child support order, who is responsible for providing health coverage?	Custodial Parent's Name, if applicable
1.				
2.				
3.				
4.				

Use reverse side to add additional dependents.

Section 3: Verification

I hereby verify that the above information is true, complete and accurate to the best of my knowledge.

Participant's Signature:

Date:

Telephone #: