Coordination of Benefits (COB) Form

Integrated Behavioral Health
P.O. Box 30018, Laguna Niguel, CA 92607-0018
Telephone: (800) 395-1616 Fax: (714) 556-5430

Insured Name: _____ Insured's SS#: _____

Address: _____ Employer: _____

City, State zipcode: _____

Patient Name: _____ DOB: _____

Under the terms of the plan, dependents, which are covered by any other group insurance or group pre-payment plan which is paid for, in whole or part, by another employer are subject to "Coordination of Benefits". Your cooperation in having the ***insured*** provide the following information is appreciated and will expedite the processing of your claim.

Is Patient covered by another mental health plan? YES NO

If Patient is eligible for other coverage please complete the following information regarding the other policyholder's coverage:

Other Insured's Name: _____

Other Insured's Employer: _____

Other Insured's Date of Birth: _____

Insurance Carrier's Name: _____

Insurance Carrier's Address: _____

_____

Effective Date of Coverage: _____

Does the plan provide Dependent coverage: YES NO

If a dependent child and natural parents are divorced or separated:

1.) Who does the child reside with? Mother Father
2.) Is there a court order for insurance coverage? YES NO
3.) Who is responsible for primary insurance coverage? Father Mother Joint

I certify that the above information is correct.

Employee's Signature: _____

Date: _____

This information will be reviewed annually. If you have a change in insurance status please notify us in writing.

IBH Claims