

Coordination of Benefits Questionnaire

Coordination of Benefits
PO BOX 91110
Sioux Falls, SD 57109-1110

Customer Service: (800) 752-5863
NDPERS Customer Service: (800) 499-3416

SANFORD
HEALTH PLAN

If you have insurance coverage with another health plan or Medicare, you must inform us to coordinate your benefits and share the cost of your health care. **In order to process claims correctly, please complete and return this form as soon as possible, as future claims will not be processed if this form is not received.**

Member Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Member ID Number: _____

Type of Health Coverage

While covered by Sanford Health Plan, have you or any of your family members been covered by another:
Health Plan (including Medicare) Yes No **Dental Plan** Yes No **Prescription Plan** Yes No

If you checked “Yes” to any box above, please complete all applicable fields on the form. If you checked “No” in all the boxes above, please sign and date the form. When complete, return to Sanford Health Plan:

- By mail at the address above
- By fax at (605) 705-2765
- By emailing this form or necessary information to Healthplancob@sanfordhealth.org
- By contacting Customer Service using the information above.

Other Coverage/Medicare Information

Name of other insurance company:	Effective date of other coverage:
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Phone number of other insurance company:	Policyholder’s name with other insurance:
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First and last names of members on this policy:

Policyholder’s date of birth with other insurance:	Member ID number:
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Medicare ID number:	Medicare Only - Effective date(s):		
	Part A:	Part B:	Part C:

Divorce Decree/Child Support Orders/Court Orders

Is there a divorce decree/ child support order /court order that orders one or both parents to provide health insurance for any covered dependents: Yes No

- **If yes, a copy of the divorce decree/ child support order /court order is REQUIRED and will only be used for claims processing.**

Person(s) required to carry health insurance per divorce decree/court order (first and last name(s))

Person with Primary Physical Custody:

Signature

Subscriber Signature:	Date:
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