

Why am I being asked to complete this form?

Many of our members have other health insurance coverage in addition to their Tufts Health Plan policy. For example, many people have coverage through their working spouse, and most people over 65 have Medicare. We must have basic policy information for all other coverage you maintain while you are a Tufts Health Plan member.

Why do you need this information?

When you have more than one insurance policy, we work with the carrier of the other policy to ensure that your claims are paid accurately. We can process your claims faster and without delays if we have complete, up-to-date information regarding your coverage.

Am I required to supply this information, or is it optional?

According to your Evidence of Coverage, which you received after you enrolled, you are required to tell us about any other health insurance held by anyone covered under your Tufts Health Plan policy. We are only concerned with other insurance that is also in effect while you are covered by Tufts Health Plan.

Please note that we reserve the right to withhold payment on claims pending confirmation of your other insurance information. If you do not have other insurance, please explicitly state this on the form and return it to us.

I am no longer covered by Tufts Health Plan. Do I still have to respond?

Yes, if your Tufts Health Plan coverage was in effect at any time during the last 18 months.

We are only concerned with other insurance that was in effect while you were covered by Tufts Health Plan. We do not need to know about any insurance that started after your Tufts Health Plan coverage terminated.

I am single/I have no children. Why are you asking about my spouse and children?

This questionnaire is used for all members, regardless of whether they are single or married, or whether they have children. You need only answer the relevant questions.

I have other insurance but I choose not to use it. Do you still need the information?

Yes. If your other medical insurance is in effect, Tufts Health Plan will need this information.

I have other questions.

For questions about this material or the accompanying questionnaire, please call the Coordination of Benefits Department at **(800) 801-8087**, between 8 a.m. and 4 p.m., Monday through Friday. For other questions, please call the Tufts Health Plan Member Services Department at the number on the back of your ID card.

Please return the questionnaire to:

Tufts Health Plan COB
P.O. Box 9165
Watertown, MA 02471

Name of Tufts Health Plan subscriber: _____ Tufts Health Plan Policy ID number: _____

SECTION 1 – EMPLOYMENT STATUS

Are you or your spouse actively working? (If YES, please complete the employment information.)

Tufts Health Plan policy holder: NO YES Employer _____ Phone # (____) _____

Spouse: NO YES Employer _____ Phone # (____) _____

Have you or your spouse retired? (If YES, please complete the retirement and former employer information.)

Tufts Health Plan policy holder : NO YES Retirement Date ___/___/___ Employer _____

Spouse: NO YES Retirement Date ___/___/___ Employer _____

Do you, your spouse, or children receive Social Security benefits as a result of a disability?

Tufts Health Plan policy holder: NO YES Date of Disability ___/___/___

Spouse: NO YES Date of Disability ___/___/___

Children: Name _____ NO YES Date of Disability ___/___/___

Name _____ NO YES Date of Disability ___/___/___

SECTION 2 – MEDICARE

Are you, your spouse or children covered by Medicare?

Tufts Health Plan policy holder: NO YES (If YES, refer to your Medicare card to complete)

Spouse: NO YES (If YES, refer to your Medicare card to complete)

Children: NO YES (If YES, refer to your Medicare card to complete)

Name of Cardholder	Medicare ID#	Effective Dates	Medicare Entitlement Reason (check)
		Part A: ___/___/___ Part B: ___/___/___	Age <input type="checkbox"/> Disability <input type="checkbox"/> Kidney Failure <input type="checkbox"/>
		Part A: ___/___/___ Part B: ___/___/___	Age <input type="checkbox"/> Disability <input type="checkbox"/> Kidney Failure <input type="checkbox"/>
		Part A: ___/___/___ Part B: ___/___/___	Age <input type="checkbox"/> Disability <input type="checkbox"/> Kidney Failure <input type="checkbox"/>
		Part A: ___/___/___ Part B: ___/___/___	Age <input type="checkbox"/> Disability <input type="checkbox"/> Kidney Failure <input type="checkbox"/>

SECTION 3—OTHER HEALTH INSURANCE

At this time or at any time in the last 12 months, are/were any members covered under your Tufts Health Plan policy, including yourself, your spouse or children, also covered by any other health insurance plan?

If YES, please refer to the *other* insurance card to complete this section. If NO, please proceed to Section 4.

Other Health Insurance company name _____ Company Phone (____) _____

Effective Date: _____ Group # _____ Member ID # _____

Name of person holding other insurance: _____ Date of Birth of other policy holder: _____

Does this other insurance cover you, your spouse or children?

Tufts Health Plan policy holder: NO YES

Spouse: NO YES

Children: NO YES

SECTION 4—AUTHORIZATION

Name of person completing this form (please print): _____

I certify that the above information is true and correct to the best of my knowledge:

Signature: _____ Phone #(____) _____ Date: ___/___/___

E-mail address: _____

Please return this form to us at Tufts Health Plan COB, P.O. Box 9165, Watertown, MA 02471. Thank you!