DENVER HEALTH MEDICAL PLAN INC.™

COORDINATION OF BENEFITS

OTHER HEALTH INSURANCE FORM

If you have more than one health insurance plan, you must tell Denver Health Medical Plan (DHMP). DHMP uses Coordination of Benefits (COB) when processing your claims by telling DHMP which plan should pay the claim first and second.

In order to process your claims and ensure you receive the maximum benefits available, information regarding other health care coverage is needed. Please complete the information below, sign the bottom of the form, and send to the address provided. Please return the completed form **within 10 calendar days**, as Federal and state laws require that we make timely claim decisions.

SECTION 1: MEMBERS COVERED BY DHMP				
Member ID #	**First Name**	**Last Name**	**Date of Birth**	**Other Coverage?**
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No

Fill in information below for all other coverage. If needed, complete a second form for additional carriers.
If you provide a copy of Member ID Card(s) for all other coverage, skip Section 2 below and move on to Section 3.

SECTION 2: IDENTIFY OTHER CARRIER INFORMATION		
Policyholder Name: (please print)	**Date of Birth:** | |	**Group/Plan #:**
Relationship to DHMP Member:	**Member ID #:**	
Carrier Name:	**Carrier Address:**	
Carrier City, State, Zip:	**Carrier Phone #:**	

Member Names Covered Under This Policy:	**Member ID #s Covered Under This Policy:**

(Medicaid and CHP+ members can skip Section 3 below and move on to Section 4)

If your dependent child(ren) is/are covered under another plan and the biological parents are divorced or separated, we will need the following information for coordination of benefits and payments:

Is either parent required by a divorce decree to carry health coverage? ◯ Mother ◯ Father ◯ Both

You must provide us with a copy of the divorce decree and/or parenting plan, and the custodial parent's name, address and phone number, so we can determine the correct order of benefits and to whom we should send potential overpayments.

SECTION 3: SUPPORT/CUSTODY INFORMATION				
	First Name	**Last Name**	**Date of Birth**	**Insurance Name**
Biological parent with custody				
Step parent with custody				
Biological parent without custody				
Step parent without custody				

SECTION 4: POLICYHOLDER SIGNATURE	
The statements made above are true and correct to the best of my knowledge.	
Policyholder Signature:	**Date:** / /

SECTION 5: SEND COMPLETED FORM TO DHMP	
Mail To: Denver Health Medical Plan, Inc. Attn: Coordination of Benefits 938 Bannock Street Denver, CO 80204	**Fax To:** 303-602-2095

SECTION 6: PRIVACY ACT STATEMENT

The statement serves to inform you of the purpose for collecting your personal information and how that information will be used.

PURPOSE: To collect information from you in order to process your medical and prescription drug claims under your Insurance Benefit Plan and to coordinate payment activities with other health insurance that may be available to you or members of your family.

ROUTINE USES: Your records may be disclosed to federal and state agencies and to other health insurance carriers in order to coordinate your benefits and payments for health care and prescription drugs received.

DISCLOSURE: Voluntary. If you chose not to provide this information, no penalty may be imposed, but failure to provide the requested information in a timely manner may result in the delay or denial of payments and claims or retrospective take back of monies paid on previously paid claims.

If you have any questions regarding this form, please contact Health Plan Services at the telephone number on your Member ID Card.