DENVER HEALTH MEDICAL PLAN INC.™

COORDINATION OF BENEFITS FORM

If you have more than one health insurance plan, you must tell Denver Health Medical Plan (DHMP). DHMP uses Coordination of Benefits known as COB when processing your healthcare bills. Tell DHMP which plan should pay your healthcare bills first and then second.

To process your health care bill, we need information regarding other health care insurance you may have. Please fill out the information below. Sign the bottom of the form. Send the form to the address given. Please return the completed form **within 10 calendar days** so that we can process your bill quickly.

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. Complete a second form if needed. **If you give us a copy of your Member ID Card, you can Skip Section 2 and go 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:**

Medicare, Medicaid and CHP+ members can skip Section 3 and move on to Section 4.

When your dependent children are covered under another plan or the parents are divorced or separated, we need more information.

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. It should include the custodial parent's name, address, and phone number.

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 777 Bannock St., MC 6000 Denver, CO 80204	**Fax To:** 303-602-2095