WELCOME!

Terms and Conditions of Use:

1. This site provides an electronic version of your Coordination of Benefits Form. It is provided as a convenience to employers and employees.

2. We strive to ensure that the contents of this site are correct and complete, but to verify your benefits, please call HealthPartners Member Services.

3. This information is not an offer of coverage or guarantee of coverage. All products are subject to applicable laws and regulations. Your coverage is contingent on all the applicable terms, conditions, limitations and exclusions of your plan documents.

4. Any alteration of this PDF file is unauthorized.

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COORDINATION OF BENEFITS FORM
CLAIMS DEPARTMENT
8100 34th Avenue South • PO BOX 1309
Minneapolis, MN 55440-1309

Please complete the information below and return this form to HealthPartners. If you have questions regarding this form, please contact Claims Department at (952) 883-7755.

The HealthPartners Membership Contract contains a "Coordination of Benefits" provision which allows HealthPartners to share responsibility of covering health care expenses with any other company that covers you or your family for medical or dental benefits. When health care expenses are shared between two or more companies, payment up to 100 percent of eligible charges may be provided thereby reducing a member's out-of-pocket expenses. In addition to benefitting the individual member, coordination of benefits is beneficial to all members because it avoids duplication of payments which would result in higher premium rates.

HealthPartners Policyholder (Applicant) Name ____________________ Date of Birth ____________

Employer Name ______________________________

Social Security Number ____________________ HealthPartners Member Number ____________

1. Does spouse or Spousal Equivalent of HealthPartners policyholder have health insurance other than with HealthPartners? ☐ YES ☐ NO If YES, complete Section A; if NO, go to question 2.
2. Are you divorced or remarried? ☐ YES ☐ NO If YES, complete Section B; if NO, go to question 3.
3. Do you have Medicare (Part A or Parts A&B) or Medicaid? ☐ YES ☐ NO If YES, complete Section C; if NO, please sign below.

Section A

Please complete Section A with information about other health insurance only (do not complete this section if other policy terminates when HealthPartners coverage takes effect):

Name of Spouse or Spousal Equivalent of HealthPartners Policyholder ____________ Date of Birth ________ Social Security Number ________

Spouse or Spousal Equivalent's Employer Name and Address ______________________________

Employer's Health Plan Name ______________________________

Address for Submitting Claims ______________________________

Policy Number ____________ Effective Date ________ Cancellation Date ________

☐ Single Coverage ☐ Family Coverage

If Family Coverage, list all covered members ______________________________

Section B

If you are divorced or remarried with dependents, please provide complete health insurance information if different from above for all dependents

Dependent	Person responsible for dependent health care expenses per divorce decree	Plan Name	Plan Address	Policy Number	Policyholder Name

Section C

This section is to be completed only for Medicare (Part A or Parts A & B) or Medicaid information, not other health insurance.

Health Plan Name	Name of Person Covered	Policy Number	Effective Date

I certify that the above information is true and correct. I authorize the administrator of the above named plan(s) to release information to HealthPartners regarding health care benefits to which I may be entitled. I understand that the purpose of this release of information is to assure appropriate coordination of benefits of all plans. I authorize the assignment of benefits to the providers of service.

This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand that a photocopy of this authorization shall be valid as the original.

SIGNATURE OF APPLICANT ____________ SPOUSE OR SPOUSAL EQUIVALENT SIGNATURE ____________ DATE ________

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