

To help expedite the processing of claims, please provide HealthPartners the following information about any other insurance you or your dependents may have. Mail your information to:

HealthPartners
 P.O. Box 1289
 Minneapolis, MN 55440-1289

If you have any questions about Coordination of Benefits or this form, please call HealthPartners Member Services:
 (952) 883-5000 or 1-800-883-2177

CLAIMS:

In most cases, your HealthPartners network providers will submit claims on your behalf. If you use an out-of-network provider or receive a bill that you think should be covered by your HealthPartners plan, please send itemized medical bills to:

HealthPartners
 P.O. Box 1289
 Minneapolis, MN 55440-1289

HealthPartners Policyholder Name _____

Social Security # _____ Date of Birth _____

Employer Name _____ HealthPartners Member # _____

	<i>No</i>	<i>Yes</i>	<i>If yes:</i>
I and/or my dependents have other health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<i>Complete Section A on back</i>
I have covered dependents and I have divorced or remarried	<input type="checkbox"/>	<input type="checkbox"/>	<i>Complete Section B on back</i>

Coordination of Benefits and Utilization/Claims Reporting Authorization

I authorize HealthPartners to release general medical information concerning my family's treatment to the administrators of any other health plan providing coverage to me or my covered dependents. I authorize the administrators of any other health plan providing coverage to me or my dependents to release information to HealthPartners about health care benefits to which we may be entitled. I understand that the purpose of the release of information is to assure appropriate coordination of benefits of all plans.

I understand that HealthPartners may release information about services provided under my health benefits contract when requested by the employer/organization sponsoring my benefits plan. This information will be reported without identification of individuals to maintain patient confidentiality.

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

I understand that a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. I hereby declare the information provided to be true and accurate.

SIGNATURE OF POLICYHOLDER _____ DATE SIGNED _____

The following information helps us determine if and when we need to coordinate claims payments with another insurance company and helps to expedite the processing of your claims.

Section A Other Health Insurance Information	
Name of other health insurance policyholder: _____	
Date of birth of other health insurance policyholder: _____	
Name of other insurance company: _____	
Address: _____	
Policy/Group # : _____	Effective date: _____
Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	

Section B Divorced and/or Remarried with Dependents Information			
Dependent's full name	Name of person(s) with legal custody	Person(s) responsible for dependent's healthcare expenses per divorce decree	
		Name	Date of Birth