

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 and/or dependents have claims for illness or injury that may be covered by:

- | | No | Yes | If yes: |
|---|--------------------------|--------------------------|---------------------------|
| • Other health insurance | <input type="checkbox"/> | <input type="checkbox"/> | <i>Complete Section A</i> |
| • No-fault insurance covering motor vehicle accident injuries | <input type="checkbox"/> | <input type="checkbox"/> | <i>Complete Section B</i> |
| • Workers' compensation covering work related illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | <i>Complete Section C</i> |
| • Third-party liability covering injuries occurring on another person's or company's property | <input type="checkbox"/> | <input type="checkbox"/> | <i>Complete Section D</i> |

I have covered dependents and I have divorced or remarried: *Complete Section E*

Date Signature

If you answered YES to any of the above, please fill out the reverse side of this form.

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Section A Other Health Insurance Information

Name of policyholder of other health insurance _____
Date of birth of other insurance policyholder _____
Name of other insurance company _____
Address _____ Phone # _____
Policy/Group # _____ Effective date _____ Type of coverage: Single ____ Family ____

Section B No Fault Insurance Information

Name of family member affected _____ Date of original injury _____
Describe injury _____
Name of affected family member's auto insurance carrier _____
Carrier address _____ Carrier phone # _____
Claim #, if known _____ Attorney, if retained _____ Phone # _____

Section C Workers' Compensation (Work. Comp.) Insurance Information

Name of family member affected _____ Date of original injury _____
Describe injury _____
Name of affected family member's employer _____
Name of affected family member's work. comp. carrier _____
Work. comp. carrier address _____
Work. comp. carrier phone # _____ Claim #, if known _____
Attorney, if one has been retained _____ Phone # _____

Section D Third Party Liability Information

Name of family member affected _____ Date of original injury _____
Describe injury _____
Name of person or establishment with financial responsibility for the injury _____
Person/establishment address _____ Phone _____
Attorney, if one has been retained _____ Phone _____

Section E Divorced and/or Remarried with Dependents Information

Child's complete name	Name of person(s) with legal custody	Name and date of birth of person(s) responsible for dependent health-care expenses per divorce decree
_____	_____	_____
_____	_____	_____