HealthPartners®
Your health. Your partner.℠

COORDINATION OF BENEFITS AND CLAIM INFORMATION FORM

CLAIMS DEPARTMENT
8170 33rd Avenue South, PO Box 1289
Bloomington, MN 55425-1289
www.healthpartners.com

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	☐	☐	*Complete Section A*
• No-fault insurance covering motor vehicle accident injuries	☐	☐	*Complete Section B*
• Workers' compensation covering work related illness or injury	☐	☐	*Complete Section C*
• Third-party liability covering injuries occurring on another person's or company's property	☐	☐	*Complete Section D*
I have covered dependents and I have divorced or remarried:	☐	☐	*Complete Section E*

_____ _____

Date Signature

If you anwered 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