



Coordination of Benefits Indicator Form

Date: _____

Member Information

Name: _____

Head of Household (if different from above): _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Date of Birth: _____

SSN: _____ Member ID #: _____

Medicare information:

Name (last, first, MI): _____ Claim number: _____

Part A: Start date _____ End date: _____

Part B: Start date _____ End date: _____

Commercial health insurance information

New policy Changed policy Terminated/closed policy

Additional policy Policy ended due to leaving job

Policyholder's name (last, first MI): _____

Date of Birth: _____ SSN: _____ Policy #: _____

Group number: _____ Policy start date: _____ Policy end date: _____

Insurance company

Name: _____

Address: _____

Telephone: _____

Family members covered

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Access to employer-sponsored health insurance

If not currently insured, does any family member's employer offer health insurance? Yes No

Employer/union name: _____

Employer/union address: _____

Employer/union telephone: _____

Mail or fax this form to:
BMC HealthNet Plan
Provider Audit and Other Party Liability
Two Copley Place, Suite 600, Boston MA 02116
(617) 748-6188 Fax: (617) 897- 0851