COMMON GROUND

HEALTHCARE COOPERATIVE

Coordination of Benefits Eligibility Form

Common Ground Healthcare Cooperative (CGHC) requires additional information related to Coordination of Benefits (COB) to accurately process your claims. Please complete the information below and return within thirty-one (31) days, so the processing of your claims will not be delayed.

I. Coordination of Benefits Determination

1. Do you or someone on your CGHC policy have other health insurance coverage? ☐Yes ☐No
   a. If you answered "No", please sign, date and return using one of the options below.
2. Is the other health insurance coverage received through an employer? ☐Yes ☐No
3. What coverage is included in your other insurance: ☐Medical ☐Supplemental ☐Prescription ☐Other
   a. If you answered "Other", please advise the type of coverage: _____

II. Other Carrier Information

1. Name: _____
2. Address: _____
   Street

   _____
   City State Zip Code
3. Phone Number: _____

III. Covered Person(s) Information

4. Subscriber Name: First Name: _____ Last Name: _____
5. Subscriber Date of Birth (MM/DD/YYYY): ____ / ____ / _____
6. Policy ID Number: _____ Group ID Number: _____
7. Name of person(s) currently enrolled with the other health insurance coverage?
   a. First Name: _____ Last Name: _____ Effective Date: _____
   b. First Name: _____ Last Name: _____ Effective Date: _____
   c. First Name: _____ Last Name: _____ Effective Date: _____
   d. First Name: _____ Last Name: _____ Effective Date: _____
   e. First Name: _____ Last Name: _____ Effective Date: _____
   f. First Name: _____ Last Name: _____ Effective Date: _____

The enclosed notice contains details on CGHC non-discrimination and the availability of language assistance services.

IV. Court Order Requirements Information

8. Is there a Court Order specifying a person(s) to maintain health insurance coverage for any of your dependent(s)? ☐Yes ☐No

9. Name of person(s) with Court Order specifying maintenance of health insurance coverage is required:

   a. First Name: _____ Last Name: _____ Effective Date: _____

   b. First Name: _____ Last Name: _____ Effective Date: _____

   c. First Name: _____ Last Name: _____ Effective Date: _____

   d. First Name: _____ Last Name: _____ Effective Date: _____

V. Eligibility Form Submission

1. CGHC Subscriber Name (Print): _____

2. CGHC Member ID Number: _____

3. Subscriber Signature: _____ Date: _____

Please return this completed and signed form within 31 days of the date of this letter using one of the options below:

Mail the form to:
Common Ground Healthcare Cooperative
120 Bishop's Way, Suite 150
Brookfield, WI 53005

Email the form to:
info@commongroundhealthcare.org

Contact Member Services:
(to provide this information verbally)
#1-877-514-2442

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