COMMON GROUND

HEALTHCARE COOPERATIVE

Coordination of Benefits Eligibility Form

Common Ground Healthcare Cooperative (CGHC) requires additional information related to other insurance you might have. We need to determine which insurance policy is primary to coordinate benefits between the plans. This helps ensure accuracy processing 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 covered by 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 Insurance 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: _____

We need to receive the completed and signed form within 31 days of the date listed on the Coordination of Benefits (COB) letter.

Please send the form to us using one of the options below:

Mail	**Email**	**Phone**
Common Ground Healthcare Cooperative 120 Bishop's Way, Suite 150 Brookfield, WI 53005	info@commongroundhealthcare.org	**1.877.514.2442** (to provide this information verbally to Member Services)

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