COMMON GROUND
HEALTHCARE COOPERATIVE

Coordination of Benefits (COB)

Common Ground Healthcare Cooperative (CGHC) requires information related to Coordination of Benefits (COB) to accurately process your claims. Return the form within thirty-one (31) days to ensure the processing of your claims will not be delayed.

☐ **Yes, myself or someone on my CGHC policy has other health insurance coverage.**

☐ **No, no one on my CGHC policy has other health insurance coverage.**
If you choose "no," please simply sign, date and return.

OTHER COVERAGE INFORMATION

What type of health insurance policy is this? ☐ Employer-based ☐ Not through an Employer

Coverage Type: ☐ Medical ☐ Supplemental ☐ Prescription ☐ Dental ☐ Other

Other Carrier Information		
Carrier Name:		Phone:
Address:		
City:	State:	Zip:
Subscriber Name:	Date of Birth:	
Policy ID:	Group ID:	

List all dependents covered by this other carrier plan.

Dependent Name(s):	**Effective date(s):**

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

Dependent Name(s):	**Effective date(s):**

PO Box 1630, Brookfield, WI 53008-1630 | P: 1.877.514.2442 | F: 262.754.9690 | www.CommonGroundHealthcare.org

Medicare Coverage Information

Do you have Medicare health insurance coverage? ☐Yes ☐No
If no, and you are 65 years old or older what is the reason for not taking Medicare?

If yes, reason for Medicare coverage is:

☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease (ESRD)*

***For ESRD*, please provide the following:**
When did dialysis treatment begin? (mm/dd/yyyy):
How did ESRD treatment start? ☐ in a facility ☐ as self-dialysis or home dialysis
Has a transplant been performed? ☐ Yes ☐ No If yes, date of the transplant (mm/dd/yyyy):

***For Medicare*, please provide the following:**

Name of Medicare Beneficiary:	Medicare number, including alpha character(s):	Medicare Part A Effective date (mm/dd/yyyy)	Medicare Part B Effective date (mm/dd/yyyy)	Medicare Part C Effective date (mm/dd/yyyy)	Medicare Part D Effective date (mm/dd/yyyy)
			☐ Elected not to take	☐ Elected not to take	☐ Elected not to take
If Medicare Advantage (Part C) is elected, provide name of carrier:					
			☐ Elected not to take	☐ Elected not to take	☐ Elected not to take
If Medicare Advantage (Part C) is elected, provide name of carrier:					

Please return this completed and signed form within 31 days of the date of this letter to:

Mail: CGHC Enrollment & Billing
PO Box 1630
Brookfield, WI 53008-1630
Email: info@commongroundhealthcare.org

Subscriber's Name (Print)_____ CGHC Member ID_____

Subscriber's Signature _____ Date: _____

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