Together with CCHP
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | togetherCCHP.org

Coordination of Benefits Verification

Together with CCHP wants to make sure that your claims are processed timely and accurately, especially when you are covered by more than one health insurance plan. Please complete this form to help us ensure that your health insurance claims are processed correctly. Failure to complete and return this form may result in denial of claim payments.

Thank you for your assistance in providing this information. If you have questions or concerns, call Customer Service at 1-844-201-4672. Please return this form to Together with CCHP at the address or fax number listed at the end of the form.

Member Information

MEMBER NAME _____ MEMBER ID NO _____ DATE OF BIRTH _____

Other Insurance Information

If you need additional space, please attach a separate sheet of paper.

1. **Are you or any family member covered by another health insurance plan (i.e., another employer's medical plan, Medicare, HMO, PPO, POS, or indemnity health plan)?**

   ☐ **No** You are finished with this inquiry. Please return this verification form to Together with CCHP at the address / number listed at the end of this form.

   ☐ **Yes** Please provide information on the other health insurance policies covering you and/or your family below.

   Plan Type: _____

   Name of Insurance Carrier: _____

   Address of Insurance Carrier: _____

   Member ID No.: _____ Eff. Date: _____

   Policyholder Name: _____

   Family Members covered by plan: _____

   Does this policy include coverage for prescription drugs? ☐ Yes ☐ No

2. **Do you or a family member have a separate insurance policy (other than listed previously) that covers prescription drugs?**

   ☐ **No**

   ☐ **Yes** Please complete the information below.

   Name of prescription drug plan: _____

   Phone number of drug plan: _____

Internal Reference: TOG Member Form – Coordination of Benefits Verification (2019.0917)

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3. Do you have dependent children whose health insurance coverage is provided by another person due to divorce, court decisions, or custody agreements?

☐ **No**

☐ **Yes** Please complete the information below.

Person Responsible for Insurance Coverage: _____

Plan Type: _____

Insurance Carrier: _____

Insurance Carrier Address: _____

Insurance Phone Number: _____

Member ID No.: _____ Effective Date: _____

Policyholder Name: _____

Family members covered by plan: _____

Does this policy include coverage for prescription drugs? ☐ Yes ☐ No

4. If dependent children are covered by more than one insurance and there is not a court order in place, who has physical custody of the dependent children?

Name of Person with Physical Custody: _____

Relationship to Dependent Children: _____

5. Does anyone in your family have coverage under Medicare?

☐ **No**

☐ **Yes** Please complete the information below.

Beneficiary Name: _____

Medicare Health Insurance Claim Number (HICN): _____ Eff. Date: _____

Coverage: ☐ Part A ☐ Part B ☐ Parts A + B

6. If entitled due to End Stage Renal Disease, please provide the following information.

Original Dialysis Date: _____

Type of Dialysis (select) ☐ CCPD ☐ CAPD ☐ Hemodialysis (center-based)

Have you had a Kidney Transplant? ☐ No ☐ Yes – if yes, date:

To the best of my knowledge, all statements made within this verification are true and accurate.

_____
CONTRACT HOLDER'S SIGNATURE

_____
DATE

How to submit this form:
- By Mail: Together with CCHP
  PO Box 106012
  Pittsburgh, Pennsylvania 15230-6012
- By Fax: 1-844-201-4673

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