Coordination of benefits

If you are covered by other medical, vision, pharmacy or dental health plan, we coordinate benefits with other insurers to help you receive the full benefit of those plans. By coordinating benefits, we may be able to reduce your out-of-pocket expenses for covered services.

We request information regarding other insurance upon your initial enrollment and on an annual basis for verification of any changes that may have happened during the year. In order to prevent your claim from being delayed or denied please take a moment to complete this form and return it to us within 10 days. To avoid delays, please fill out and return the form even if you do not have other coverage.

Please let us know if you or any family members have other medical, vision, pharmacy or dental coverage now (including Medicare and Medicaid) or if one has existed in the last 12 months. Please attach a separate sheet for any additional plan information.

Do you or any family members have any other medical, vision, pharmacy or dental health coverage now (including Medicare and Medicaid)? Has other health coverage existed in the last 12 months? If multiple health coverage exists, or has been in place in the last 12 months, attach a separate sheet for any additional plan information.

Please type or print legibly in ink, completing all information requested and sign in Section 8. Thank you!

Section 1 › Member/subscriber information

Member/subscriber (first)	Member/subscriber (last)	Subscriber ID number
Member/subscriber phone	Member/subscriber email	

Section 2 › Other medical insurance

Is there other **medical** insurance? ○ Yes (If yes, complete the section below) ○ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Effective date of other carrier coverage	Termination date of other carrier coverage
Other insurance type: ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Student ☐ Short term ☐ Medicare supplement ☐ Other (please specify):		
Names of those covered by other insurance carrier		

Section 3 › Other vision insurance

Is there other **vision** insurance? ○ Yes (If yes, complete the section below) ○ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Effective date of other carrier coverage	Termination date of other carrier coverage
Other insurance type: ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Other (please specify):		
Names of those covered by other insurance carrier		

Section 4 › Other pharmacy insurance

Is there other **pharmacy** insurance? ○ Yes (If yes, complete the section below) ○ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Effective date of other carrier coverage	Termination date of other carrier coverage
Other insurance type: ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Student ☐ Short term ☐ Medicare supplement ☐ Other (please specify):		
Names of those covered by other insurance carrier		

Section 5 › Other dental insurance

Is there other **dental** insurance? ○ Yes (If yes, complete the section below) ○ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Effective date of other carrier coverage	Termination date of other carrier coverage
Other insurance type: ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Other (please specify):		
Names of those covered by other insurance carrier		

Section 6 › Medicare coverage information

Name of member on Medicare	Member's Medicare ID no.	Member's birth date
Effective date of Medicare PART A	Effective date of Medicare PART B	
Effective date of Medicare PART C	Effective date of Medicare PART D	
Did you opt out of Medicare PART B coverage that you were eligible to enroll in? ○ Yes ○ No		
Reason for Medicare coverage: ☐ Age 65 or older ☐ Disability, due to: ☐ End stage renal disease (ESRD), date dialysis began:		

Section 7 › Separated or divorced parents

If parents of the children covered by Summit Health are separated, divorced or not living together, please complete this section.

Is there a court order stating that one of the parents is responsible for the healthcare expenses of the child(ren)? ○ Yes ○ No (if no, continue to next section)	Please list the names of the children the court order applies to:
If you answered "yes" to the above question, what is the name of the person responsible and their relationship to the child(ren)	

If there is no court order allocating responsibility for healthcare coverage to one parent, please complete this section.

Is there joint custody or does the order state that both parents are responsible for the child's healthcare expenses? ○ Yes ○ No	Please list the names of the children this applies to:
If you answered "no" to the above question, what is the name of the person who has custody and their relationship to the child(ren)?	

Complete this section if either parent has remarried.

Custodial parent information		
Name		Birth date
Carrier	ID or Policy No.	
Carrier's phone number	Effective date of other carrier coverage	Termination date of other carrier coverage

Non-custodial parent information		
Name		Birth date
Carrier	ID or Policy No.	
Carrier's phone number	Effective date of other carrier coverage	Termination date of other carrier coverage

Custodial spouse or domestic partner information		
Name		Birth date
Carrier	ID or Policy No.	
Carrier's phone number	Effective date of other carrier coverage	Termination date of other carrier coverage

Non-custodial spouse or domestic partner information		
Name		Birth date
Carrier	ID or Policy No.	
Carrier's phone number	Effective date of other carrier coverage	Termination date of other carrier coverage

Section 8 > Authorization

We appreciate the time you have taken to complete the information on this form.

Your signature below, certifies that the information you have entered on this form is true and correct to the best of your knowledge. You agree to contact us immediately should changes occur with any of your coverage.

Signature of member/subscriber X		Date
Daytime phone of member/subscriber	Email of member/subscriber	

Ready to submit? Mail this form to Summit Health:

Mail: P.O. Box 820070, Portland, OR 97282

Questions? We're here to help. Contact our Customer Service department toll-free at 844-827-2355. (TTY users, dial 711.)

yoursummithealth.com