Dear Member,

Enclosed please find a "**Coordination of Benefits Questionnaire"**. This form is being sent to you because a claim has been received for you or your dependent(s) that indicates there is possible coverage through another health plan. In order to determine which plan is the primary carrier, the attached form **MUST** be completed and returned to Verdegard Administrators, LLC. Please make sure you complete the entire form and include a copy of the other insurance I.D. card(s) for each carrier if applicable.

Dependent Children of divorced or separated parents please clearly indicate *which parent* has custody of the dependent child so coordination of benefits can be determined. Please include a copy of the divorce decree if possible.

If you or your dependent(s) are no longer covered under another insurance plan you MUST submit a Creditable Coverage Letter from the prior insurance carrier to Verdegard Administrators, LLC.

Please note that all claims submitted will be denied until a completed Coordination of Benefits (COB) survey is received by Verdegard. The COB survey is necessary to determine whether you have any other insurance coverage that may be primary to the coverage being claimed. Until we receive a completed COB survey, we will not be able to process your claim. We apologize for any inconvenience this may cause and encourage you to complete the survey as soon as possible to ensure timely processing of your claim. For questions please contact Verdegard at (888) 811-8944.

Thank you,

Verdegard Administrators, LLC
Enrollment Department

Coordination of Benefits Questionnaire
Verdegard Administrators, LLC
P.O. Box 22009, Tempe, AZ 85285-2009
Phone: (888) 811-8944 Fax: (480) 800 5838

Please submit a separate form for each Other Insurance Carrier

FAMILY MEMBERS COVERED UNDER VERDEGARD POLICY

Full Name	Verdegard Member ID number	Date of Birth	**Is this member covered under Other Insurance Carrier specified below?
Employee:			
Spouse:			
Child 1:			
Child 2:			
Child 3:			
Child 4:			

Please use reverse side if additional space is needed.

Name of Other Insurance:	Phone Number:
Address:	
Full Name of policy holder:	
Is this coverage for Medicaid?	Policy Holder Date of Birth:
Policy Number:	Group Name or Number:
Check what is covered under this policy: Medical Dental Vision Pharmacy	Please indicate the effective date:

Include a copy of the front & back of other Insurance Carrier ID card.
If this coverage is no longer in effect, you must submit a Creditable Coverage Letter from this carrier.

Is this coverage for Medicare?	
Check if it is coverage for Part A, Part B, or Both: Part A Part B Both	
Do you carry Medicare due to a disability? (please check Yes or No below) Yes No	
If you check Yes above, please explain:	
Do you carry Medicare due to end stage renal disease? (please check Yes or No below) Yes No	
If you check Yes above, please explain:	

The above information provided will only be used to coordinate benefits.

Signature Date

PLEASE NOTE THAT FAILURE TO COMPLETE & RETURN THIS FORM COULD RESULT IN DELAY OR TERMINATION OF BENEFITS