Eliance Health Solutions
Lancaster General Health

Please return completed form to:
Eliance Administrators, Attn: Customer Service
P.O. Box 7046, Lancaster, PA 17604-7046
Fax: 717-553-1125
Questions? Call 717-553-1124 or 1-855-408-8503

Coordination of Benefits Questionnaire

Your health plan contains a Coordination of Benefits (COB) provision. This determines which plan is primary when more than one plan covers the individual. Please complete this form as soon as possible and return to Eliance Administrators to prevent a delay in processing your or your family's medical claims.

Section A. SUBSCRIBER INFORMATION

Subscriber (employee) Name:	Group#: Family ID #:
Subscriber's Employer:	Date of Birth: Daytime Phone#:
Spouse's Name: ☐ Not married	Spouse Date of Birth: Enrolled in Employer's Health Plan? ☐ Yes ☐ No
Spouse's Current Employer: ☐ Not employed	If Spouse does not have other coverage, please indicate why:

Are you, your spouse or your dependents enrolled in any other health plan coverage, other than this plan? This can include coverage through another employer, the Marketplace Exchange, Medicare or Medicaid.

☐ Yes. (complete all applicable Sections and sign Section E) ☐ No (Complete Section E)

Section B. Other Coverage for Dependents (Spouse & Children)

Complete for each individual with other coverage. Please provide a copy of the other plan's identification card

Dependent Name 1:	Effective Date:	Termination Date:
Plan Subscriber Name:	Relationship to Subscriber:	
Subscriber Date of Birth:	Plan Phone #:	Plan ID#:
Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Retiree ☐ COBRA ☐ Marketplace Exchange ☐ Other (explain):	Plan Name: Dependent Covered Under Medicare? ☐ Yes ☐ No If "Yes," complete Section D	
Dependent Name 2:	Effective Date:	Termination Date:
Plan Subscriber Name:	Relationship to Subscriber:	
Subscriber Date of Birth:	Plan Phone #:	Plan ID#:
Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Retiree ☐ COBRA ☐ Marketplace Exchange ☐ Other (explain):	Plan Name: Dependent Covered Under Medicare? ☐ Yes ☐ No If "Yes," complete Section D	
Dependent Name 3:	Effective Date:	Termination Date:
Plan Subscriber Name:	Relationship to Subscriber:	
Subscriber Date of Birth:	Plan Phone #:	Plan ID#:
Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Retiree ☐ COBRA ☐ Marketplace Exchange ☐ Other (explain):	Plan Name: Dependent Covered Under Medicare? ☐ Yes ☐ No If "Yes," complete Section D	

Use the back of this form for more dependents or for further explanation

Section C. OTHER DEPENDENT CHILD(REN) INFORMATION

Complete this Section if you are divorced, legally separated, or a single parent, and you have dependent children under this plan

Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental or other health care expenses? ☐ No ☐ Yes

List the name(s) of dependent(s):

If yes, who is the person(s) responsible to maintain health coverage?	With whom do the child(ren) live?
What is the relationship to the child(ren)?	How many months of the year?

Section D. MEDICARE COVERAGE

Complete this Section if you, your spouse and/or dependent child(ren) are eligible for Medicare. Please provide a copy of the Medicare ID card for each eligible member of your family.

Name of Member Eligible for Medicare:	Name of Member Eligible for Medicare:
Effective Dates of Medicare: Part A: Part B: Part D:	Effective Dates of Medicare: Part A: Part B: Part D:
Reason for Medicare: ☐ Age 65 or older ☐ Disability - 1st Date of Disability: ☐ End Stage Renal Disease (ERSD) 1st Date of Dialysis for ESRD: Was ESRD started in a facility? ☐ Yes ☐ No Was ESRD started as Self Dialysis or Home Dialysis? ☐ Yes ☐ No Has a transplant been performed? ☐ Yes ☐ No If yes, please provide date of the transplant:	Reason for Medicare: ☐ Age 65 or older ☐ Disability - 1st Date of Disability: ☐ End Stage Renal Disease (ERSD) 1st Date of Dialysis for ESRD: Was ESRD started in a facility? ☐ Yes ☐ No Was ESRD started as Self Dialysis or Home Dialysis? ☐ Yes ☐ No Has a transplant been performed? ☐ Yes ☐ No If yes, please provide date of the transplant:

Section E. SUBSCRIBER SIGNATURE

I certify that the information provided on this form is correct and I understand that I am obligated to provide this information according to the provisions of my health plan. I also understand that I must notify my employer, in writing, if there are any changes to the information I provided above. My failure to provide complete and accurate information may result in a delay in the processing of my claims for benefits.

Signature of Subscriber: Date:

Caution: Any person who knowingly and with the intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.