Coordination of benefits

MercyCare subscriber name: _____

MercyCare subscriber number: _____ Date of Birth: _____

Employer group number and name: _____

Dear subscriber,
To ensure proper and timely payment of your claims, please provide the following information and return in the enclosed postage paid envelope within 15 days. Should you have any questions regarding this, or if your information should change, please call our customer service department at (800) 895-2421. Thank you for your cooperation in this important process.

1. **Are you married?** No ____ Yes ____
   *If yes, please answer questions 2 through 5. If no, please skip to questions 6 through 7.
2. **Is your spouse currently employed?** No ____ Yes ____ Spouse's Date of Birth: _____
   *If yes, please provide the following:

   Employer name: _____

   Phone: _____

   Address: _____
3. **Does your spouse have insurance through his or her employer?** No ____ Yes ____
   *If yes, please provide the following:

   Insurance co. name: _____

   Policy/subscriber number: _____

   Phone: _____

   Effective date of coverage: _____
4. **If you answered yes to question # 3, please advise if your spouse's insurance plan includes prescription coverage.** No_____ Yes _____

   *If yes, please provide the following information:

   Plan name: _____

   Phone: _____Group #: _____
5. **Please list all members covered by your spouse's plan:**

   _____ _____

   _____ _____

MercyCare Health Plans™

Coordination of benefits
continued

6. Are you or any of your dependents covered by Medicare?
   No _____ Yes _____ *If yes, please fill in the information below.

   Name:_____

   Medicare number: _____

   Medicare Part A effective date: _____

   Medicare Part B effective date: _____

   Medicare Part D effective date: _____ Drug plan name:_____

   Name:_____

   Medicare number: _____

   Medicare Part A effective date: _____

   Medicare Part B effective date: _____

   Medicare Part D effective date: _____ Drug plan name:_____

7. Are you or any of your dependents covered through another policy?
   (Please include any coverage dependents may have under a separated/divorce parent)

   No ____ Yes ___ *If yes, please provide the following:

   Insurance co. name: _____ Phone number:_____

   Policy holder name: _____

   Effective date of coverage: _____ Member ID number:_____

   If divorced, attach a copy of the court order.

   Other coverage also includes any state aid program, such as BadgerCare Plus.

MercyCare Health Plans™