Coordination of Benefits Verification Form (Required)

TriHealth Benefit Solutions (TBS) wants to process your claims timely and accurately, especially when you are covered by more than one health insurance plan. Please complete this form to assist TBS in processing your health insurance claims 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 TBS Customer Service Department at 1-833-999-4TBS (4827). Please return this form to TBS at the address or email listed at the end of the form.

I. SUBSCRIBER INFORMATION (to be completed by policyholder)

Last Name	First Name, Middle Initial	Date of Birth (MM/DD/YYYY)
Group Number	Health Plan ID Number	Daytime Phone Number
Street Address	City, State, Zip	Primary Care Physician (PCP)
		PCP Facility Location

II. OTHER INSURANCE INFORMATION

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

Are you or a family member covered by another health insurance plan (i.e., another employer's medical plan, Medicaid, HMO, PPO, POS, or indemnity health plan?

☐ No You are finished with this section.
☐ Yes Please provide information below on the other health insurance policies covering you and/or your family below.

Plan Type ☐ Other Insurance ☐ Student Health ☐ Medicaid Please indicate if Plan is Primary or Secondary ☐ Primary ☐ Secondary	**Family Members Covered by Plan**	
	Name (First, Last)	Date of Birth Relationship
	Name (First, Last)	Date of Birth Relationship
	Name (First, Last)	Date of Birth Relationship
Subscriber Name (policyholder)	Street Address, City, State, Zip	Daytime Phone Number
Other Insurance Carrier Name	Effective Date of Coverage	Other Insurance Carrier Address
Other Insurance Carrier Phone Number	Other Insurance Carrier ID Number	Is the subscriber: ☐ Active ☐ Retired ☐ On Cobra

III. MEDICARE

Does anyone in your family have coverage under Medicare?

☐ No You are finished with this section.
☐ Yes Please complete the information below for each person with Medicare coverage.

Reason for Medicare Coverage (Select all that apply) ☐ Age ☐ Disability ☐ End Stage Renal Disease	Beneficiary Name (First, Last)	Medicare Member ID
Coverage (Select one) ☐ Part A only ☐ Part B only ☐ Parts A and B	Relationship	Effective Date

IV. End Stage Renal Disease

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

Original Dialysis Date ____ / ____ / ____

Type of Dialysis (select one)	Transplant	If Yes, indicate date below
☐ Home Dialysis ☐ Dialysis in facility/dialysis center	☐ Yes ☐ No	____ / ____ / ____

V. OTHER INSURANCE INFORMATION DUE TO DIVORCE, COURT DECISIONS, OR CUSTODY AGREEMENTS

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

☐ No You are finished with this section.
☐ Yes Please complete the information below.

Name of Person Responsible for Insurance Coverage	**Family Members Covered by Plan**	
	Name (First, Last)	Date of Birth Relationship
Please indicate if Plan is Primary or Secondary ☐ Primary ☐ Secondary	Name (First, Last)	Date of Birth Relationship
	Name (First, Last)	Date of Birth Relationship
Subscriber Name (policyholder)	Street Address	City, State, Zip
Subscriber Daytime Phone Number	Other Insurance Carrier Name	Effective Date of Coverage
Other Insurance Carrier ID Number	Other Insurance Carrier Address	Other Insurance Carrier Phone Number

VI. SIGNATURE SECTION

To the best of my knowledge, all statements made within this Coordination of Benefits Verification Form are true and accurate.

SUBSCRIBER (POLICYHOLDER) SIGNATURE	DATE ____ / ____ / ____

VII. Please send the completed Coordination of Benefits Verification Form in one of the following ways:

- Mail: TriHealth Benefit Solutions
  PO Box 211775
  Eagan, MN 55121
- Email: emailtbs@trihealth.com

TriHealth Benefit Solutions
4600 Wesley Avenue
Cincinnati, OH 45212
TriHealthBenefitSolutions.com