Coordination of Benefits Information Page

* Please keep a copy of this Coordination of Benefits Information Page for your records.

Applicant Name: ____________________

Soc. Sec. #: ____________________ Date of Birth: ____________________

When completed mail or fax this form to:

Mail to: Sentara Health Plans
ATTN: Enrollment Support Services – OHI
PO Box 66189
Virginia Beach, VA 23466

Fax: 757-961-3086

NOTE: Complete section F and section H if you have additional commercial insurance.
Complete section G and section H if you have Medicare.

SECTION F (Commercial Insurance)

Name of other Insurance Company: ____________________

Address: ____________________

Phone Number: ____________________

Policy Number: ____________________ Effective Date: ____________________

Employer: ____________________ Group Number: ____________________

Policyholder's Name: ____________________ Date of Birth: ____________________

List family members covered by this insurance: ____________________

____

SECTION G (Medicare Information)

Applicant: ____________________ Claim#: ____________________

Hospital Insurance (Part A) Coverage Start Date: ____________________

Medical Insurance (Part B) Coverage Start Date: ____________________

Are you retired: ☐ Yes ☐ No Retirement Date: ____________________

Spouse: ____________________ Claim#: ____________________

Hospital Insurance (Part A) Coverage Start Date: ____________________

Medical Insurance (Part B) Coverage Start Date: ____________________

Are you retired: ☐ Yes ☐ No Retirement Date: ____________________

SECTION H

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group insurance or service plan.

____________________ ____________________

Applicant Signature Date