600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbsm.com

Blue Cross
Blue Shield
Blue Care Network
of Michigan

ZTMLCID120010800001240001002100

▶ *Your response is required **within 10 days of receiving this letter.** Please respond even if you have no other health insurance to report.*

ZTMLCID120010800001240001002100

Enrollee Name:
Enrollee ID:

Please update your coverage information

Dear

We routinely ask you to tell us whether you, your spouse or any of your covered dependents have other health insurance. We need this information to ensure that your claims are processed accurately. WE CANNOT PROCESS YOUR CLAIMS OR PAY YOU OR YOUR DOCTORS UNTIL YOU RESPOND.

Do you, your spouse or any of your covered dependents have coverage by another health care plan, excluding Medicare and auto insurance?

If your answer is "no," please respond by choosing one of the options listed below:

- **Phone:** Call our automated response line at **1-866-263-9494**.
- **Blue Cross Mobile App**: Log in, click the menu button in the top left corner, then click *My Account*, followed by *Coordination of Benefits*.
- **Online:** Visit **bcbsm.com/cob**, click *Log in to your account*, and follow the instructions.
- **Mail:** Complete Section 1 of the form on the back of this letter. Sign the form, and return it to us in the enclosed envelope.

If your answer is "yes," please respond by choosing one of the options below:

- **Online:** Visit **bcbsm.com/cob**, click *Log in to your account*, and follow the instructions.
- **By Mail:** Complete the form on the back of this letter, and return it to us in the enclosed envelope.

If you have questions about this letter, visit **bcbsm.com/cob.** If you still have questions, call the Customer Service number on the back of your card.

Sincerely,

The Group Customer Membership Department

Blue Cross Blue Shield of Michigan

COORDINATION OF BENEFITS QUESTIONNAIRE

NASCO

For your convenience, you can update your coordination of benefits information online at **bcbsm.com**. **If neither you nor your covered dependents have any additional group health coverage, simply call our automated response number at 866-263-9494.**

SECTION 1 YOUR BCBSM INFORMATION

BCBSM enrollee name (as found on your ID card)	BCBSM enrollee ID / contract number

In addition to this BCBSM contract, are you or any of your covered dependents also covered by another group health care plan other than Medicare? If you have additional BCBSM contracts, please include this as other coverage.

☐ NO – Please skip the rest of the questions, sign at the bottom and return

☐ YES – Please complete entire form, sign at the bottom and return

SECTION 2 OTHER HEALTH COVERAGE INFORMATION

Please provide the following information about the policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)

Type of coverage ☐ Single ☐ Family

Is this a retiree contract? ☐ Yes ☐ No
Is this a COBRA contract? ☐ Yes ☐ No
Is policy holder laid-off? ☐ Yes ☐ No

Type of plan: (check all that apply) ☐ Hospital ☐ Medical ☐ Dental ☐ Drugs

Who is covered by this other plan? Include yourself if applicable.

Name (first and last)	Relationship to you	Name (first and last)	Relationship to you
1.		4.	
2.		5.	
3.		6.	

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation, etc.

Is there a court order that determines responsibility for health care coverage or custody? ☐ No ☐ Yes - *(attach a copy of the sections that apply to health care responsibility and/or custody arrangements)*

Name of person responsible for child's health care coverage	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

Enrollee ID / policy number	Group number	Effective date	Cancellation date

Which children are covered by this insurance?

Child's name (first and last)	Who has custody	Child's name (first and last)	Who has custody
1.		4.	
2.		5.	
3.		6.	

Subscriber's signature: _____ **Date:** _____

Return completed forms to: National COB Membership — B340
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-9942

OR Fax: 866-581-3946