GHPA

Greater Houston Psychiatric Associates, PLLC

COORDINATION OF BENEFITS FORM

In addition to your Primary Insurance coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare?

☐ **Yes** *If yes, please complete the entire questionnaire below, sign and return to us.*

☐ **No** *If no, simply sign the form below and return to us.*

Please Print

Subscriber's Name: _____ Identification Number: _____

Subscriber's Social Security Number: _____/____/____Spouse's Social Security Number: _____/____/_____

Other Health Insurance:

1. Are you, your spouse or your dependent covered under Medicare: ☐ YES ☐ NO
   If yes, please complete the following:
2. Name of person(s) covered: _____
3. Medicare #: _____
4. Is Medicare coverage due to disability caused by end stage renal disease? ☐ YES ☐ NO
5. Date of onset: _____ Date eligible for Medicare: _____
6. Do you have part A? ☐ YES ☐ NO 7. Do you have part B? ☐ YES ☐ NO

Section II

If other coverage exists, please fill out:

1. Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

2. Policy Holder's Social Security Number: _____/____/_____Date of Birth: ____/_____/_____

3. Name of Employer providing coverage: _____

4. Name of Other Insurance Company: _____Policy Number: _____

5. Address of Other Insurance Company: _____

   Phone Number: _____

6. Effective Date of Policy: _____Cancellation Date of Policy (If Applicable): _____

7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

I certify that the above information is correct

Signature: _____ Date: _____Patient's name: _____ DOB: _____