MERITAIN HEALTH
An Aetna Company

Accessing Other Insurance Coverage Online

Your healthcare benefits plan includes a provision called coordination of benefits. This means if one person is covered by two benefit plans, both plans share responsibility for covering that person's healthcare expenses. This helps prevent duplicate payments and helps hold down healthcare costs.

Examples of other coverage include: Medicare (due to age or disability), group coverage through a family member's employer, association coverage through a group you or a family member belongs to, student health coverage, or coverage mandated by a divorce decree.

Meritain Health may sometimes ask you to update this information so we can keep our records current.

You can now complete your Coordination of Benefits (COB) online:

1. From the *Benefits and Coverage* dropdown, select *Coordination of Benefits*.
2. You'll be asked if you or any dependents have other coverage, other Medicare coverage and/or other Medicaid coverage. Simply answer *Yes* or *No* to report if you or anyone in your family has other health coverage.
3. If you answer *Yes*, you'll be asked for information about the other coverage like start date, carrier name, policy holder name and date of birth, etc. Just fill out the forms that open when you select *Yes*.
4. After you complete the form, click *Next* to see a summary of the information.
5. If you agree with the summary, click *Submit* in the bottom right corner. If you need to make changes, click *Edit* at the top of the summary.

If you have any questions, you can call Customer Service at the number on the back of your ID Card for assistance.

Other COB options are available

For your convenience, please click here for a copy of the Other Insurance Coverage Form.

- You can *email* it to: Forms.Direct@meritain.com
- Or you can *mail* it to:
  Meritain Health
  Eligibility Department
  P.O. Box 27810
  Minneapolis, MN 55427-0810
- Or *fax* to **716.541.6672**.
  You should keep a copy of the fax confirmation record if you plan to call to confirm receipt.

ADVOCATES FOR HEALTHIER LIVING

Advocates for Healthier Living

Meritain Health provides easy-to-use healthcare benefits you can use to stay healthy and productive. Contact us at the number on your ID Card if you have any questions about your plan.

Other Insurance Coverage Information

Complete and return to:

Meritain Health
Eligibility Department
P.O. Box 27810
Minneapolis, MN 55427-0810
Fax: 716.541.6672
Email: Forms.Direct@meritain.com

Meritain Health Welcomes You! We are asking for your help in getting information on other Medical/Dental insurance coverage currently in effect for you or your dependents. This information will expedite claims processing and enhance your level of service. **If we do not receive this information, it may delay the processing and payment of your claims.**

PLEASE PRINT:	
EMPLOYEE NAME	EMPLOYEE DOB
NAME OF COMPANY (YOUR EMPLOYER):	GROUP NUMBER
MEMBER ID NUMBER	

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER COVERAGE IN EFFECT AT THIS TIME?

MEDICAL: ❑ YES ❑ NO
DENTAL: ❑ YES ❑ NO
MEDICARE: ❑ YES ❑ NO

If you answered **NO** for all of the above, please return this form via fax, email or mail to the address above.
If you answered **YES** to any of the above, please provide the information below & return as directed above.

MEDICAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH (POLICY HOLDER)	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

DENTAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

MEDICARE		
DO YOU OR YOUR DEPENDENTS CURRENTLY HAVE MEDICARE COVERAGE? ❑ YES ❑ NO **IF YES, COMPLETE THE REST OF THIS SECTION.**		
NAME OF PERSONS COVERED BY MEDICARE	IF YOU OR YOUR SPOUSE ARE RETIRED, LIST NAME AND DATE OF RETIREMENT	
MEDICARE ID NUMBER:		
REASON FOR MEDICARE ELIGIBILITY: ❑ OVER AGE 65 ❑ END-STAGE RENAL DISEASE ❑ TOTAL DISABILITY		
PART A EFFECTIVE DATE(S)	PART B EFFECTIVE DATE(S)	PART D EFFECTIVE DATE(S)

OTHER COVERAGE	
IS THERE OTHER COVERAGE FOR YOUR CHILDREN DUE TO A COURT DECREE? ❑ YES ❑ NO	
IF YES, NAME OF PARENT(S) WITH LEGAL CUSTODY OF CHILDREN	ADDRESS OF PARENT(S) WITH LEGAL CUSTODY
IS THERE A COURT ORDER MAKING THE NONCUSTODIAL PARENT RESPONSIBLE FOR THE CHILDREN'S MEDICAL/DENTAL EXPENSES? ❑ YES ❑ NO IF YES, SUPPLY A COPY OF THE LEGAL DOCUMENTATION OF THIS DECISION.	
FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DENIAL OF CLAIMS SUBMITTED BY YOU AND YOUR FAMILY MEMBERS.	