HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Coordination of Benefits Form

Your prompt response will ensure that your claims are paid timely and accurately. This form is used for the sole purpose of gathering information about other healthcare carriers who provide health benefit coverage for you or your Dependent(s) in order to pay claims correctly. **Si necesita esta forma en espanol favor de llamar al (702) 242-7419.**

1. Subscriber (Employee) Name:	Subscriber's ID # (See ID Card for #):
New Address Only:	City State Zip
Home Phone #: ( )	Work Phone #: ( ) / Cell Phone #: ( )

2. Are you, your spouse or any of your Dependents covered under any Other Healthcare Plan, including Medicare or another HPN, SHL, or UHC and Affiliates plan? ☐ **NO – (Complete #2 & #4)** ☐ **YES – (Complete #2 thru #5)**

   Spouse's Name:_____ Spouse's ID# (see ID Card)_____

3. Please list yourself (if applicable) and any of your Dependents that are covered under the Other Healthcare Plan, including Medicare or another HPN, SHL, or UHC and Affiliates plan.

Name (First & Last)	Relationship to Subscriber of Other Healthcare Plan	Relationship to Subscriber (identified in #1 above)
1.	☐ Natural Child ☐ Stepchild ☐ Other (list)_____	☐ Natural Child ☐ Stepchild ☐ Other (list)_____
2.	☐ Natural Child ☐ Stepchild ☐ Other (list)_____	☐ Natural Child ☐ Stepchild ☐ Other (list)_____
3.	☐ Natural Child ☐ Stepchild ☐ Other (list)_____	☐ Natural Child ☐ Stepchild ☐ Other (list)_____
4.	☐ Natural Child ☐ Stepchild ☐ Other (list)_____	☐ Natural Child ☐ Stepchild ☐ Other (list)_____

Please provide complete information about the Other Healthcare Plan that covers the individuals identified above, including listing any other HPN, SHL, or UHC and Affiliates plan(s).

Other Healthcare Plan Subscriber's Name:_____ Date of Birth: _____

Subscriber ID #:_____ Subscriber is: ☐ Actively at work ☐ Retired ☐ Other _____

Other Healthcare Plan Name:_____ Effective Date of Coverage:_____

Other Healthcare Plan Address: _____

Other Healthcare Plan Phone:_____ Employer Name: _____

Check all appropriate boxes that applies to the Other Healthcare Plan: ☐ Single coverage ☐ Family coverage
Plan Type: ☐ HMO ☐ POS ☐ PPO ☐ Individual ☐ Medicare **Benefits:** ☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision

4. Did you, your spouse or any of your Dependents previously have healthcare coverage that has been cancelled?
   ☐ NO ☐ YES Cancelled Carrier's Name:_____ Date Cancelled:_____

5. Are any of the Dependent children on your plan covered under a divorced or separated parent's healthcare plan?
   ☐ NO (Sign, date and return this form) ☐ YES (Please complete form)

Child's Name (first & last)	Who has physical custody of child?	Mom	Dad	Other
1. _____	and _____	☐	☐	☐
2. _____	and _____	☐	☐	☐
3. _____	and _____	☐	☐	☐
4. _____	and _____	☐	☐	☐

Who is responsible for the Dependent child's healthcare coverage?	You (Subscriber)	Section 3 Plan Holder	Plan Holder (Listed on p.2)	Court Order *Yes	Court Order No
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐

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***Important:** If responsibility is determined by a Court Order, please attach a copy of the relevant section of the Court Order which deals specifically with custody and healthcare responsibility.

Please use this section to provide any additional healthcare coverage information not already provided in this Coordination of Benefits Form for the Dependent child(ren):

Subscriber's Name:_____Date of Birth:_____ Relationship to Child: _____

Name of Healthcare Carrier Providing Child's Coverage: _____

Carrier's Street Address: _____ Phone #:_____

Plan Number: _____ Group Number: _____ ID Number: _____

Effective Date of Coverage: _____ Benefits Provided: □ Medical □ Pharmacy □ Dental □ Vision

Medicare Information (If this section does not apply, please skip to signature section.)

1. Does the Subscriber and/or any Dependent(s) have Medicare coverage? □ YES □ NO
2. Name of individual(s) enrolled in Medicare: _____
3. Medicare Number, including alpha character(s): _____
4. Effective Date: Medicare Part A ____/____/____ Medicare Part B ____/_____/_____ Medicare Part D ____/____/____
5. Medicare Entitlement: □ Age □ Disability* □ End Stage Renal Disease (ESRD)*

   *If Medicare Entitlement is granted for a Disability or ESRD, please provide the following information:

   - 1st Date of Disability: ____/____/____
   - 1st Date of Dialysis for ESRD: ____/____/____
   - Was ESRD started in a facility? □ YES □ NO
   - Was ESRD started as Self-Dialysis or Home Dialysis? □ YES □ NO
6. Has a transplant been performed? □ YES □ NO If YES, please provide the date of the transplant: ___/___/____

I understand that my Authorized Representative or I am entitled to a copy of this form upon request. I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be used as the basis of acceptance for Coordination of Benefits of me and my Dependent(s) if any. I acknowledge that I understand each of the questions asked in this form as well as the terms used in those questions.

Subscriber's Signature (for self and Dependents):_____ Date: _____

Please complete, sign and date this form and return in self-addressed envelope or to the following address:

HPN, SHL, UHC and Affiliates
ATTN: Claims Investigation and Recovery Department
P.O. Box 15645
Las Vegas, NV 89114-5645

Or, you may **fax** the completed form to **(702) 242-9038**.

Should you have any questions or need assistance, please contact the Coordination of Benefits Unit at (702) 242-7419 (TDD/ADA (702) 242-9214, Monday – Friday, 8 a.m. – 5 p.m. If you are outside the Las Vegas area, please call our toll-free number: 1-800-201-7622 (TDD/ADA 1-800-349-3538).

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a healthcare company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any healthcare company or agent or a healthcare company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.