Salisbury Psychiatric Associates, PC

Coordination of Benefits

Please complete the information below. The information requested will be submitted to your insurance company. This allows verification of other coverage to coordinate benefits. Completion of this form may help to expedite the processing of your claim especially in situations where there may be overlapping insurance benefits. This form must be completed and on file before we can submit your claim.

1. Insured's Name ____________________ Date of Birth ____________________
2. Insured's Employer ____________________ Insurance Carrier ____________________
3. Social Security Number ____________________ Ins Phone # ____________________
4. Patient Name ____________________ Patient Date of Birth ____________________
5. Patient Address ____

Section I

1. Do you have other coverage through another group health plan? Yes ☐ No ☐
2. If so, are you covered as an active employee or retiree? Active ☐ Retiree ☐
3. Please indicate the name of the carrier and the effective date:
   Carrier: ____________________
   Effective Date: ____________________
4. If you are married, is your spouse employed? Yes ☐ No ☐
   If yes, name of spouse's employer: ____________________
   Spouse's date of birth: ____________________
5. Does your spouse have group coverage through his/her employer? Yes ☐ No ☐
   (If yes, please complete Section II)

Section II

1. Name of spouse's insurance carrier: ____________________ Phone #: __________
2. Insured ID/SSN: ____________________ Group/Policy number: ____________________
3. Effective Date: ____________________ Termination Date: ____________________
4. Type of coverage: Individual ☐ Family ☐

Section III

If you have children, and are legally separated or divorced, please complete.

1. Is there a court decree stating financial responsibility? Yes ☐ No ☐
2. Who has responsibility? ____________________
3. Who has custody of the children? ____________________
4. Does anyone other than the natural parents carry insurance on the dependents?
   Yes ☐ No ☐
   If yes, please provide Name of Policyholder: ____________________
   Insurance Carrier: ____________________ ID/SSN: ____________________

Section IV

1. Are you, your spouse, or your dependents covered under Medicare? Yes ☐ No ☐
   If yes, please complete the following:
2. Name and date of birth of person(s) covered: ____________________
3. Medicare ID: ____________________ Date Eligible: ____________________
4. Do you have part A? Yes ☐ No ☐ Do you have part B? Yes ☐ No ☐

I certify that the above information is correct to the best of my knowledge

Insured's Signature: ______________________________ **Date:** ____________________

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