BlueCross BlueShield Nebraska

Member Name: _____

Member ID: _____

COORDINATION OF BENEFITS FORM

For the fastest processing, log into your **myNebraskaBlue.com** account; the Coordination of Benefits form can be found in the *Action Items* section.

Section 1 – Member Insurance Information

Are you, your spouse or dependent children covered by any other medical and/or dental coverage?

☐ No, only Blue Cross and Blue Shield of Nebraska (Complete Section 7)	☐ Yes, **other** insurance or TRICARE (Complete Sections 2-5 & 7)	☐ Yes, Medicare (Complete Sections 6 & 7)	☐ Yes, Medicaid or CHAMPUS/VA (Complete Section 7)

Section 2 – Other Insurance/TRICARE Information

Please list all applicable health and/or dental insurance carriers in the space provided. Attach another sheet if needed.

Insurance Company Name or TRICARE Insurance Administrator	Insurance Company or TRICARE Admin Phone Number	Type of Coverage (select all that apply)	Type of Enrollment (select one)	Other Insurance/ TRICARE Effective Date (mm/dd/yyyy)	TRICARE Status (select one)
		☐ Medical/Physician ☐ Hospital ☐ Prescription Drug ☐ Dental	☐ Single ☐ Family ☐ Employee/Spouse ☐ Employee/Child		☐ Active ☐ Reserves ☐ Retiree

Section 3 - Policyholder Information for Other Insurance

Policyholder on the policy indicated in section 2:

Last Name:	First Name:
Identification Number (include all letters and numbers):	Policyholder DOB:
Employer Name, if applicable:	

Relationship to policyholder listed at the top: ☐ Self ☐ Spouse ☐ Dependent ☐ Ex or legally separated spouse ☐ Other

If relationship is "Self" or "Spouse", indicate employment status:

- ☐ Actively working with employer offering other coverage
- ☐ Not actively working/ long-term disability
- ☐ Retired from employer providing other coverage
  - Retirement date _____
- ☐ On COBRA
  - COBRA effective date _____

Section 4 - Covered Persons

Complete the following information for all persons covered under the other policy. Attach a separate sheet if needed.

Covered Person First and Last Name	Relationship to the policyholder in Section 3 (i.e. self, spouse, child, step-child, custodial parent)	Date of Birth (mm/dd/yyyy)	Mark if covered by Medicare or Medicaid	Mark if dependents are covered under court order
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐
5.			☐	☐
6.			☐	☐

Section 5 - Parents that are Divorced, Legally Separated or Never Married

Only complete this section if dependent children are covered under the other policy and the parents are divorced, legally separated or were never married.

If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the court order.	☐ Mother	☐ Father	☐ Joint Responsibility	☐ Legal Guardian
If there is no legally binding agreement for health care expense, who has primary custody?	☐ Mother	☐ Father	☐ Joint Legal Custody	☐ Legal Guardian

Section 6 - Medicare Enrollee Information

Beneficiary Name	Medicare ID	Employment Status	Coverage Type	Effective Date (mm/dd/yyyy)	Medicare Entitlement Reason
		☐ Employed ☐ Retired Date:_____	☐ Part A ☐ Part B ☐ Part D	_____ _____ _____	☐ Age ☐ Disability ☐ ESRD
		☐ Employed ☐ Retired Date:_____	☐ Part A ☐ Part B ☐ Part D	_____ _____ _____	☐ Age ☐ Disability ☐ ESRD

Section 7 - Policyholder Signature

_____ _____

Signature Date

Daytime Phone Number: _____

BlueCross BlueShield Nebraska

Instructions for Coordination of Benefit Form

Coordination of Benefits (COB) applies when more than one insurance company provides you and/or your family members with health care benefits. COB is applicable to you and all family members that are covered under your current health and/or dental plans.

The following instructions can be used to assist you in filling out the attached COB form.

Complete and submit the attached hard copy, which can be mailed or faxed back to us.

Mail to:
Blue Cross and Blue Shield of Nebraska
PO Box 3248
Omaha NE 68180-0001
Fax to: 402–392-4126

Section 1 – Member Insurance Information:
If you or any of your dependents are not covered under another health or dental plan, answer No and skip to Section 7. Please sign and date and provide a daytime phone number so we can contact you if we have any questions. Your form will need to be returned to us at the address or fax number above.

If you or any of your dependents are covered under another health or dental plan, please select Yes to all other answers that apply.

If you answered "Yes, **other insurance or TRICARE,"** complete Sections 2 – 5, and 7. If you answered "Yes, Medicare," you will need to compete Sections 6 and 7.

If you answered "Yes, Medicaid or CHAMPUS/VA," you only need to complete Section 7.

Section 2 – Other Insurance/TRICARE Information:
You only need to complete this section if you answered **"Yes, other insurance or TRICARE"** in Section 1. Please provide the name and phone number of the other health and/or dental companies that cover you and/or your dependents. Indicate the type of coverage, type of enrollment and effective date. Please select all that apply to you and your family.

If covered under TRICARE, in addition to the coverage and enrollment type questions, please provide status and effective date. Effective date only needs to be provided for active and retiree status.

If you have coverage with more than two other insurance companies, please attach a sheet including all the information indicated.

Section 3 – Policyholder Information of Other Insurance:
Complete this section if you answered **"Yes, other insurance, or TRICARE"** in Section 1. This information pertains to the additional insurance coverage you or your dependents have with another insurance company (as indicated in Section 2).

Please provide the policyholder's first and last name, identification number of the other insurance, date of birth, and employer, if applicable. Select the relationship to the policyholder and their employment status.

For example, if your spouse has additional coverage through their employer, your spouse would be the policy holder; their relationship to you would be spouse. In this example, they would mark "Actively working with employer offering other coverage."

Section 4 – Covered Persons
Complete this section if you answered “Yes, **other insurance** or TRICARE” in Section 1. “Covered persons” refers to all individuals covered under the other plan and your Blue Cross and Blue Shield of Nebraska (BCBSNE) plan. Please attached a second sheet if needed.

Section 5 – Parents that are Divorced, Legally Separated or Never Married
Complete this section if you answered “Yes, **other insurance** or TRICARE” in Section 1. Only complete this section if dependent children are covered under both your BCBSNE policy and the other policy, and the parents are divorced, legally separated or never married. Please answer the questions provided on the form and include the legal documentation, if applicable, when return the COB form.

Section 6 – Medicare Enrollee Information
Complete this section if you answered “Yes, Medicare” in Section 1. The beneficiary, Medicare ID, coverage type and effective date information can be found your Medicare identification card. Please answer all questions that apply.

Section 7 – BCBSNE Policyholder Signature
Please sign and date and provide a daytime phone number so we can contact you if we have any questions. The primary policyholder or spouse on the BCBSNE policy should sign the form. Your COB form will not be complete unless it is signed.

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Spanish (Mexico)
ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi
توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)
ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese
ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen
ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါအံၤ ဘဉ်သ့ဉ်သ့ဉ် ကအိဉ်ဒီးတ်ဂ့ၢ်တၢ်ကျိၤလၢ အရူဒိဉ်ဘဉ်ယး နလံာ်ပတံထိဉ်တၢ် မ့တမ့ၢ် တၢ်အ့ဉ်ကီၤသးန့ဉ်လီၤ.
ကွၢ်ယု မ့ၢ်နံၤမ့ၢ်သိအရူဒိဉ်လၢ လံာ်ဘိးဘဉ်သ့ဉ်ညါအံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့ၢ်ဝိလၢ မ့ၢ်နံၤလၢခံကတၢ်လၢ တၢ်ဟ်ပနီဉ်နှၤ်နၤ လၢနကဟ့ဉ်နတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ဘူးတၢ်လဲတဖဉ် မ့တမ့ၢ် မၤန့ၢ်တၢ်မၤစၢၤလၢ တၢ်ပူၤလိၤလဲတဖဉ်နှဉ်လီၤ.
နၤ မ့တမ့ၢ် ပှၤတဂၤဂၤလၢ နမၤစၢၤမ့ၢ်အိဉ်ဒီးတ်သံကွၢ်အဃိ. နအိဉ်ဒီးတ်ခွဲးတ်ယာ်လၢ ကမၤန့ၢ်တ်မၤစၢၤဒီးတ်ဂ့ၢ်တ်ကျိၤလၢ နကျိာ်လၢ တလၫ်ဘူဉ်လာ်စ့ၤဘဉ်နှဉ်လီၤ.
လၢနကကတိၤတ်ဒိး ပှၤကျိးထံတ်အဂိၢ်. ကိး1-800-991-5840.တက့ၢ်.

Korean
주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish
ئاگاداری
ڕەنگە ئەم ئاگادارییە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواربەرەکییەکانی ناو ئەم ئاگادارییە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێرێک، پەیوەندی بە 18009915840 بکە.

Lao
ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານການເງິນປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali
ध्यानाकर्षण: यो सूचनामा तपाईको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

Oromo
HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian
ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese
CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.