South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

State Group Processing Unit
Attention: COB-AXB10
P.O. Box 100605
Columbia, SC 29260-0605

Members may also complete this questionnaire through our website by logging in to My Health Toolkit on StateSC.SouthCarolinaBlues.com.

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

_____ **ID Number:** _____

_____

_____ **Date:** _____

1. Do you or any dependents have any other group health, dental, or Medicare coverage? ☐ No ☐ Yes
   IF NO, FOR EXPEDITED SERVICE PLEASE USE OUR WEBSITE TO LOG IN TO MY HEALTH TOOLKIT AND RESPOND TO THE OTHER HEALTH INSURANCE QUESTION IN THE BENEFITS SECTION. OR YOU MAY CALL CUSTOMER SERVICE AT 1-800-868-2520. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

   Your Signature _____ Date _____

2. Please list the family members covered by the other policy and the type of coverage you have.

_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
_____	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

   For additional family members, attach sheet with information.
   *** If you checked Medicare, answer number 7.**

3. Name of other policyholder. _____

   Other policyholder's date of birth _____ Relationship to you _____

4. Employer name if coverage is provided through an employer. _____

5. Name of other insurance company and effective date of policy. _____ Effective Date _____
   If policy is now terminated, please give termination date. _____ ID # _____

6. If there is a divorce or separation, please list who is responsible for the health care expenses. _____
   If there is a copy of a divorce decree, please forward a copy to us.
   If there is not a court decree, who has custody of the children? _____

*** * * * * SECTION PERTAINS TO MEDICARE COVERAGE ONLY * * * * ***

7. Are you actively working? ☐ Yes ☐ No Beginning date of employment _____ Last day of active employment _____

8. Are you or any family members covered by Medicare? ☐ No ☐ Yes If No, please sign and date below. If Yes, please complete the information below.

   • Name _____ Date of Birth _____
   Medicare Number _____ Part A Effective Date _____
   Part B Effective Date _____
   Reason for Medicare (check one)
   ☐ Age
   ☐ Disability
   ☐ ESRD Date of first dialysis _____

   • Name _____ Date of Birth _____
   Medicare Number _____ Part A Effective Date _____
   Part B Effective Date _____
   Reason for Medicare (check one)
   ☐ Age
   ☐ Disability
   ☐ ESRD Date of first dialysis _____

Your Signature _____ **Date** _____

Please return this form in the enclosed postage paid envelope.

CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT WITHOUT THIS INFORMATION

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
