Sample: COB Dependent Inquiry

DEPENDENT

CF# ____

In an effort to update our records of the above-named patient, please fill out the information below and return as soon as possible.

ANY MISREPRESENTATION REGARDING ADDITIONAL HEALTH INSURANCE COULD RESULT IN INSURANCE FRAUD. IN ORDER FOR PBH TO EFFECTIVELY MANAGE THE AVAILABLE PLAN BENEFIT, FULL DISCLOSURE OF OTHER INSURANCE COVERAGE MUST BE GIVEN AT THIS TIME.

Is the above-named dependent covered under any other behavioral health insurance plan?
Yes No
(IF NO, DISCONTINUE AND SIGN BELOW)

Name of other behavioral health insurance company_________________________________

City _______________________________________ State _____________ Zip__________

Phone Number ( ) _________________________

Group Number _______________________________ ID Number ______________

Name of primary insured under above plan ___________________ Birthdate __________

I certify that the above information is true and correct.

Signature ____ Date _________

If you have any questions, please feel free to call the PBH Provider Helpline at (800) 716-1166.

Thank You,