NEWBORN COORDINATION OF BENEFITS FORM

FOR IDENTIFICATION PURPOSES, GROUP NAME, EMPLOYEE NAME AND EMPLOYEE ID MUST BE PROVIDED ON THIS FORM.

Your Employee Benefit Plan contains a "Coordination of Benefits" provision which must be updated each time you add a newborn child to your plan. This means when a patient is covered under multiple group plans (medical, dental and/or medicaid), one payor becomes the "primary carrier" and the other becomes the "secondary carrier". The primary carrier must pay benefits before the secondary carrier can determine benefits payable.

In order to coordinate benefits appropriately, please complete, sign and date the questionnaire and return to our office at the address shown below. Please attach any additional pages as needed for your response(s). Be sure to keep a copy for your files.

This form must be fully completed and returned before any related claims can be considered for payment. Your signature will verify that information provided is correct. If you need further assistance, please contact Client Services Department. Thank you for your assistance in this matter.

Employee Name: ______________________________
Employee ID: ______________________________
Group Name or ID: ______________________________

Name of Newborn Child: ____________________ Date of Birth: ________________

The HealthFirst Subscriber is: Single ☐ Married ☐ Divorced ☐

Is there a Divorce Decree/Court Order stating who is responsible for coverage on dependents?
N/A ☐ Yes ☐ No ☐ If "Yes" please attach a copy of this portion of the Decree/Order.

If "Yes", name of responsible party. ______________________________

I. Father's Name: ____________________ Father's Birthdate: ________________

Is the Father (Natural or Adoptive) covered under any other plan?
Medical? Yes☐ No☐ Dental? Yes☐ No☐ Medicaid? Yes☐ No☐
If yes, answer the following questions:

1) Effective date of coverage: ________________

2) Name of insurance carrier or Plan: ______________________________

3) Group Number: ________________ Member Number: ________________
Phone Number: ________________

4) Do you plan to add the newborn to this Plan? Yes☐ No☐

II. Mother's Name: ______________________ Mother's Birthdate: ______________

Is the Mother (Natural or Adoptive) covered under any other plan?
MEDICAL? Yes☐ No☐ DENTAL? Yes☐ No☐ Medicaid? Yes☐ No☐
If yes, answer the following questions:

1) Effective date of coverage: ________________

2) Name of insurance carrier or Plan: ____

3) Group Number: __________________ Member Number: ___________________
Phone Number: __________________

4) Do you plan to add the newborn to this Plan? Yes☐ No☐

III. Stepparent's Name: __________________ Stepparent's Birthdate: ____________

Is the Stepparent covered under any other plan?
MEDICAL? Yes☐ No☐ DENTAL? Yes☐ No☐ Medicaid? Yes☐ No☐
If yes, answer the following questions:

1) Effective date of coverage: ________________

2) Name of insurance carrier or Plan: ____

3) Group Number: __________________ Member Number: ___________________
Phone Number: __________________

4) Do you plan to add the newborn to this Plan? Yes☐ No☐

_____________________________________ _____________________
Signature of Our Subscriber Date

IF ANY OF THE ABOVE INFORMATION CHANGES, YOU ARE REQUIRED TO NOTIFY HealthFirst IMMEDIATELY, IN WRITING.