

Coordination of Benefits Questionnaire



As a student and/or dependent enrolled in medical coverage with University of California, it is a requirement to provide all primary health insurance coverage information to Anthem Blue Cross.

Please answer the following questionnaire to the best of your knowledge:

Member Name

Member ID #

Campus Name

Do you have any other medical insurance? Yes No

If you indicated No, there is no need to go further. If you indicated **yes**, please continue.

Is your other medical coverage offered through?

Name of Subscriber/Policyholder

Sub/Policyholder/Date of Birth

Policy Effective date

Group/Policy Number

Name of Other Insurance Company

Other Insurance Company Phone Number

Other Insurance Company Mailing Address

City

State

Zip Code

Do you have Medicare? Yes No

If Yes, what is your Medicare Claim Number

Effective Date for Part A

Effective Date for Part B

Effective Date for Part D

Are you Medicare eligible because?

By completion and submission of this form, you certify that the information you are providing is complete and accurate.

**Once you have completed the questionnaire, please email it to:
UCSHIPCOBIinquires@wellpoint.com**