Coordination of Benefits

Section 1 – Policyholder Information

Do you or another family member have other health coverage that may cover your claims? If no, please provide the information within section one, sign and date. If yes, please complete all applicable sections, sign and date.

Name of Judi Health Subscriber:	
Date of Birth:	ID Number:
Name of Employer Group:	Effective Date:

Section 2 – Other Coverage Information

Patient Name:	Date of Birth:
Subscriber Name:	Date of Birth:
☐ Student Health ☐ Medicaid ☐ Medicare ☐ Other	
Other Health Plan (OHP) Name:	Effective Date:
OHP Address:	
OHP Phone Number:	OHP Member ID:
Patient Relationship to Subscriber:	
Is the Subscriber: ☐ Active ☐ Retired ☐ On Cobra	If Retired, Enter Retirement Date:

Section 3 – Dependent Child Only

If your child(ren) are the patient with other insurance, please complete the below section. Please include a copy of any relevant court orders or custody orders.

Patient ID if Different than Subscriber:	
Father's Name & Date of Birth:	Mother's Name & Date of Birth:
If Separated or Divorced: Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental or other health care expenses? ☐ Yes ☐ No If yes, specify who:	
Who has custody of the dependent child(ren)?	
Who do the child(ren) live with?	How many months of the year?

Section 4 – Medicare Only

Only complete this section if you indicated the other health plan is Medicare.

Beneficiary Name:	
Medicare Type (check all that apply): ☐ Part A Only ☐ Part B Only ☐ Medicare Advantage (Part C) ☐ Part D	
Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease	
If entitled due to end stage renal disease, please provide:	
The first date of dialysis:	Date of transplant, (if applicable):

Section 5 – Signature

Please sign and date the form.

Print Name of the Person Completing the Form:	
Signature:	**Date:**

Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:

E-mail: eligibility@judihealth.com
Fax: 833-FAX-JHLT (329-5458)
Mail: Judi Health Attn: Eligibility Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008