PLAN YEAR 2020

Cleveland Clinic (CC)/Akron General (AG) EHP Employee (Print) _____ **ID Card EHP No.:** _____

SSN: _____ **Date of Birth:** _____ **LETTER CODE: 700**

Do (did) you or your participating dependents have other Medical, Pharmacy, Dental, Vision, Medicare or Medicaid coverage in **2019 and/or 2020?** ☐ YES ☐ NO

Please complete the form and refer to the letter for submission instructions.

OTHER INSURANCE INFORMATION (NON MEDICARE) ***Please enclose a copy of the other insurance ID cards.***

Policyholder's Name _____ Relationship to CC/AG Employee _____

Policyholder's Date of Birth ___/___/___ ID No. _____ Group No. _____

Original Effective Date ___/___/___ Policy Term Date (*if applicable **) ___/___/___ ***Please provide a copy of Creditable Coverage Letter(s).***

Policy Obtained Through: ☐ Group Employment ☐ Individual Purchase ☐ Student ☐ Medicaid ☐ Other_____

Policy Status: ☐ Active Benefits ☐ Retiree Benefits ☐ COBRA **Policy Covers**: ☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision

Policy Type: ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family ☐ Other _____

Name of Other Insurance Company _____ Customer Service Telephone No. _____

Name of Employer _____

Please complete columns below for those covered under the other insurance policy listed above. Use additional COB forms if necessary.

Last Name	First Name	Date of Birth	Relationship	Effective Date	Term Date

Is there legal documentation stating who is responsible for carrying the healthcare coverage for you or your dependents?
☐ YES ☐ NO ***If yes, legal documents must accompany the form stating who is responsible for carrying healthcare coverage.***

Name of Custodial Parent _____

_____

MEDICARE INSURANCE INFORMATION ***Please enclose a copy of your Medicare card.***

Medicare ID No. _____

Medicare Recipient Name _____

Effective Date: Part A ___/___/___ Part B ___/___/___

Medicare Coverage is the result of:

☐ Age (65 years)

☐ Disability _____/_____/_____ Date Approved for Medicare Benefits

☐ End-Stage Renal Disease

If yes, please check one of the following:

☐ Transplant _____/_____/_____ Date of Transplant

☐ Dialysis _____/_____/_____ Date of First Dialysis

Please check one: ☐ Home Dialysis ☐ Facility Dialysis

Medicare ID No. _____

Medicare Recipient Name _____

Effective Date: Part A ___/___/___ Part B ___/___/___

Medicare Coverage is the result of:

☐ Age (65 years)

☐ Disability _____/_____/_____ Date Approved for Medicare Benefits

☐ End-Stage Renal Disease

If yes, please check one of the following:

☐ Transplant _____/_____/_____ Date of Transplant

☐ Dialysis _____/_____/_____ Date of First Dialysis

Please check one: ☐ Home Dialysis ☐ Facility Dialysis

CC/AG Employee Signature _____ **Date**___/___/___

Ohio Revised Code Section 3999.21 – Insurance Fraud Warning "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

CLEVELAND CLINIC/AKRON GENERAL EMPLOYEE HEALTH PLAN
COORDINATION OF BENEFITS (COB) FORM

Coordination of Benefits (COB) is the process used to pay healthcare insurance policy expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare or Medicaid. If you/your dependents are covered by more than one healthcare insurance policy, Mutual Health Services (MHS), the Cleveland Clinic Employee Health Plan (EHP) Third-Party Administrator (TPA), follows rules established by Ohio law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). The combined payments of all healthcare insurance policies will not exceed the actual amount of your bills.

The following three options are available for submitting your COB information to MHS:

1. **Cleveland Clinic:** Complete the online COB form via the MHS website as follows: https://chn.mutualhealthservices.com. **OR** You can access the website via the ONE HR Workday and Portal. Once you log in, click "ONE HR Portal," then "ONE HR." From the "My Health" drop down, click on "Medical Claims, RX & more", then click the "Coordination of Benefits" tab in the Key Features bar. . Click on "Mutual Health Services". Sign in, and then click on "Health Plan Claims – Cleveland Employees Only." Click on "Continue." You will see the COB tab at the top.
   Akron General: Complete the online COB form via the MHS website as follows: https://chn.mutualhealthservices.com. **OR** Contact your HR Representative for assistance.

   Please note: If you have legal documentation stating who is responsible for providing healthcare for the dependent children covered on your health plan, and/or you have other insurance in the current or prior plan year, then you may not *submit* your COB information via the web site. You may enter your COB information via the web site and then print and send it, along with your legal document, via mail or fax to MHS.

2. Complete the form, where applicable, then sign the bottom of the COB form, and return to MHS via Fax or U.S. mail.

   Fax Number: Mutual Health Services
   Administrative Service Department: 440-878-5487

   Mailing Address: Mutual Health Services
   Administrative Service Department
   PO Box 89472
   Cleveland, OH 44101-6472

   Remember to include the following information (if applicable) for all parties on your EHP with your completed COB form:
   - **Attach a *copy* of the other healthcare insurance ID card(s)**
   - **Attach a *copy* of the Medicare card(s)**
   - **Attach a *copy* of the certificate of creditable coverage for each person terminated on another healthcare insurance policy**

3. If no other insurance existed in the plan year being updated or the prior plan year, Call MHS Customer Service at 1-800-451-7929. The interactive voice response (IVR) system is available 24/7 to accept COB updates. A live, Customer Service Representative is available to personally assist you during regular business hours (Monday-Friday, 8am-5pm)

NOTE: Be advised that if you have other insurance and there is legal documentation regarding who is responsible for providing healthcare coverage for the dependent children on your health plan, then the legal documentation must accompany your COB information.

NOTE: Forms that are incomplete could be sent back for additional information and will delay the processing of your claim(s).