Cleveland Clinic 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, Aetna, the Cleveland Clinic Employee Health Plan (EHP) Third-Party Administrator (TPA), follows rules established by 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 options are available for submitting your COB information to Aetna:

- **Online:** Complete the COB process via the Aetna Member website as follows:
  https://www.aetna.com/about-us/login.html
  - After logging into your Aetna Health website account, please select "Benefits" at the top of the page.
  - Next, click the purple link that states "view the original Coverage & Benefits page".
  - Next, click "Profile" at the top of the page, then "Your Other Insurance".
- **Fax:** 859.455.8650, Attn: A376077
- **Mail:** Aetna
  Attn: A376077
  P.O. Box 981106
  El Paso, TX 79998-1106

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

If no other insurance existed in the plan year being updated or the prior plan year, Call Aetna's Customer Service at 833.414.2331.

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).

Cleveland Clinic

COB Form

EHP Employee: _____ Aetna ID No: _____

SSN: _____ / ____ / _____ Date of Birth: _____ /_____ /_____

Do you or your participating dependents have other Medical, Pharmacy, Dental, Vision, Medicare or Medicaid coverage?
☐ 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 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 ___/___/_____

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Date of First Dialysis

Please check one: ☐ Home Dialysis ☐ Facility Dialysis

CC 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."