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](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).
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 Customer Service Other Insurance Company: ___________________________ 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.

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<th>LAST NAME</th>
<th>FIRST NAME</th>
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<th>RELATIONSHIP</th>
<th>EFFECTIVE DATE</th>
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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 ID No.: ___________________________

Medicare Recipient Name: ___________________________ Medicare Recipient Name: ___________________________

Effective Date: Part A _____ / ____ / _______ Part B _____ / ____ / _______

Medicare Coverage is the result of:
☐ Age (65 years)
☐ Disability
☐ End-Stage Renal Disease  If yes, please check one of the following:
☐ Transplant
☐ Dialysis
☐ Home Dialysis ☐ Facility Dialysis

Date approved for Medicare Benefits Date of Transplant

Date of First Dialysis

Medicare Coverage is the result of:
☐ Age (65 years)
☐ Disability
☐ End-Stage Renal Disease  If yes, please check one of the following:
☐ Transplant
☐ Dialysis
☐ Home Dialysis ☐ Facility Dialysis

Date approved for Medicare Benefits Date of Transplant

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.”

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