Phoenix Children's

COORDINATION OF BENEFITS

Apply Patient Label

By coordinating benefits among all insurance carriers, the insured receives the maximum benefits available.
* Information on this form needs to match the information on the insurance card*

Patient's Last Name: _____ First Name: _____ Patient's Date of Birth: _____

PRIMARY INSURANCE

Subscriber's Full Name: _____ Subscriber's DOB: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _____

Subscriber's Phone #: _____ Subscriber's Employer: _____

Primary Insurance Plan: _____ Subscriber/Member ID#: _____ Group # _____

Insurance Billing Address: _____ Insurance Phone # _____

Name and Date of Birth of both Parents/Legally Authorized Representatives	Parent/LAR Name: _____ Date of Birth: _____	Parent/LAR Name:_____ Date of Birth: _____

Email Address of Parent/LAR: _____ Email Address of Parent/LAR: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND PHOTO ID TO THE REGISTRAR

Please provide the patient's CRS (Children's Rehabilitative Services) ID# (if applicable.) _____

OTHER INSURANCE:

Subscriber's Full Name: _____ Subscriber's Date of Birth: _____

Subscriber's Phone #: _____ Subscriber's Employer: _____

Other Insurance Plan: _____ Subscriber/Member ID#: _____ Group # _____

Insurance Billing Address: _____ Insurance Phone # _____

*****If the patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following.*****

Relationship of other insurance member to child: ☐ Self ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _____

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _____

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _____

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes ☐ No

Relationship of party decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other _____

Name of responsible party: _____

Address: _____ Phone #: _____

Does the Patient have MEDICARE? ☐ YES ☐ NO **If Yes, is Medicare Primary?** ☐ YES ☐ NO

Name of Individual Covered by Medicare: _____ Date of Birth: _____

Medicare ID#: _____

☐ Part A_____ ☐ Part B _____ ☐ Part D *(Prescription Drug Coverage)* _____
Effective Date *Effective Date* *Effective Date*

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease

Date disability began: _____
First date of Dialysis: _____
Kidney Transplant Date: _____

****Medicare Secondary Payer Questionnaire Must Be Completed****

_____ _____
Signature of Person Completing Form Date

_____ _____
Printed Name of Person Completing Form Relationship to Patient