Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Request for Other Coverage Information

For your claims to be processed timely, this Coordination of Benefits (COB) form is required **if you or dependents on your policy** have coverage through another medical health insurance plan.

Please complete and return this form to:

ATTN: COB Department - Exchange
Arkansas Blue Cross Blue Shield
P.O. Box 2181
Little Rock, AR 72203-9974

If you have any questions, please call 1-800-800-4298, Monday - Friday, between 8 a.m. and 5 p.m.

Policyholder Name _____

Policy Number _____

Marital Status

☐ Never Married ☐ Married ☐ Single
☐ Domestic Partner ☐ Separated ☒ Divorced

Section A - Other Medical Health Insurance

Please complete this section if you, your spouse, or dependents have coverage other than this plan.
(Use additional paper if necessary.)

First Name	Last Name	Relationship	Effective Date (mm/dd/yyyy)	Termination Date	Reside in Same Household?
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No

Insurance carrier name _____ **Phone Number** _____

Insurance carrier address _____

Policyholder name _____ **Policy ID#** _____

Date of birth ___ / ___ / _____ (Mo / Day / Year) **Address** _____

Please see reverse side. Signature needed.

Section B - Dependent Children of Separated/Divorced Parents

Please complete this section for any dependent child(ren) listed in Section A whose parents are divorced, legally separated, or who have some other legal reason for providing coverage. (Use additional paper if necessary.)

Dependent First Name	Dependent Last Name	Relationship	Other Insurance Carrier	Policy ID#	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____

Other insurance policyholder name ______________________________ **Date of birth** ___ / ___ / _____
Mo Day Year

Other insurance responsible due to

☐ Custody ☐ Divorce Decree ☐ Child Support Order

If any of these boxes are checked, please enclose a copy of the complete document that establishes financial responsibility for medical care.

Section C - Medicare

Please complete this section if you or someone on your policy also has Medicare.

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

Section D - Signature

I certify that the information provided on this form is true, complete and correct.

Policyholder Signature ______________________________ **Date** ___ / ___ / _____
Mo Day Year

☐ I certify that the information provided on this form is true, complete and correct.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.