



## Medical Network Coordination of Benefits Form

In order to accurately pay medical claims in the coming year, it is necessary for the Medical and/or Dental Administrator of Medical Network to know if you or your dependents are enrolled in any other medical/dental insurance. Your medical plan requires the documentation of any other insurance at least once a year. For information about your medical/dental plan's provisions regarding coordination of benefits, please refer to your Medical/Dental Plan Document.

After completing this form, please use the self-addressed envelope and return it to:

**Medical Network  
P.O. Box 828  
Colorado Springs, CO 80901**

Failure to return this form may result in delayed payment of medical claims to you and/or your physician. If you have any questions regarding this form, please call Medical Network @ (719) 365-5025 or by email at [mednetweb@mymednet.com](mailto:mednetweb@mymednet.com).

Print your name: \_\_\_\_\_

Employee Social Security Number or Subscriber ID: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

**Are you, your spouse, or any of your eligible dependent children enrolled in any other medical/dental insurance plan?** YES \_\_\_\_\_ NO \_\_\_\_\_

**If NO:** Please sign and date at the end of the second page. You do not have to complete the remaining questions.

**If YES:** Please provide the name, address and policy number of the other insurance company. You may submit a copy of the front and back of the insurance card or write in the space below. **Other insurance does include Medicare.**

Insurance Company's Name: \_\_\_\_\_

Address and Phone Number or Subscriber ID: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Date of Other Coverage: \_\_\_\_\_

**Please list all members in your family who are enrolled with the other insurance company:**

Spouse: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse's Social Security Number or Subscriber ID: \_\_\_\_\_

Eligible Dependent Children:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Is there a Court Order stating who is responsible for providing insurance coverage for dependents?**

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please attach a copy of the court order in the form.

**Do you or your dependents have Medicare coverage?** YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please provide the following information:

Effective Date of Medicare Part A coverage: \_\_\_\_\_

Effective Date of Medicare Part B coverage: \_\_\_\_\_

Effective Date of Medicare Part D coverage: \_\_\_\_\_

**Is Medicare coverage related to End-Stage Renal Disease (ESRD)?** YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please provide the following information:

Effective Date of ESRD coverage: \_\_\_\_\_

Date of Initial Diagnosis: \_\_\_\_\_

Date of Initial Dialysis: \_\_\_\_\_

Date of Initial Transplant: \_\_\_\_\_

Have you completed a self-dialysis training program? YES \_\_\_\_\_ NO \_\_\_\_\_

The above information is true and accurate to the best of my knowledge. If the information on this form changes, I will notify Medical Network in writing so that my records will be updated in order to provide accurate medical claims processing information.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

**Return to: Medical Network - P.O. Box 828 - Colorado Springs, CO 80901**