

Coordination of Benefits Questionnaire

HMA
 1440 Kapiolani Blvd., #1020, Honolulu, HI 96814
 Phone: (808) 951-4621 Fax: (866) 298-9841



PLEASE CALL HMA ENROLLMENT DEPARTMENT AT (808) 951-4621 OR TOLL FREE AT 1 (866) 377-3977 AS SOON AS POSSIBLE AND WE WILL BE HAPPY TO ASSIST YOU IN UPDATING YOUR INFORMATION OVER THE PHONE.

FAMILY MEMBERS COVERED UNDER ANOTHER POLICY

Full Name	Social Security Number	Relationship To Employee	Date of Birth Mo/Day/Yr
Employee			
Spouse			
Child(ren)			
Child(ren)			
Child(ren)			
Chid(ren)			

Please use reverse side if additional space is needed

Name of other Insurance Carrier:	Phone Number: () -
Address:	
City, State, Zip Code:	
Full Name of policy holder:	Policy Holder Date of Birth: / /
Policy Number:	Group Name or Number:
Please check what is covered under this policy: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy	Please indicate the effective date:

If additional carriers are utilized, please explain on reverse side of this form

If this coverage is for Medicare

Please check if it is coverage for Part A, Part B, or Both: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both	
Do you carry Medicare due to a disability? (please check Yes or No below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you check Yes above please explain:	
Do you carry Medicare due to end stage renal disease? (please check Yes or No below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you check Yes above please explain:	

***The above information provided will only be used to coordinate benefits.**

Signature _____ Date _____

PLEASE NOTE THAT FAILURE TO COMPLETE & RETURN THIS FORM COULD RESULT IN A DELAY WHEN PROCESSING YOUR CLAIMS.