Saint Clare's Health

COORDINATION OF BENEFITS

Patient's Name (Please Print)

Primary Insurance Coverage:

Name of Insurance Company:

Policy ID: Effective Date:

If Medicare, please check applicable type below:

Part A: ☐ Part B: ☐ Both: ☐

Secondary Insurance Coverage:

Name of Insurance Company:

Policy ID: Effective Date:

If Medicare, please check applicable type below:

Part A: ☐ Part B: ☐ Both: ☐

Other Insurance:

Name of Insurance Company:

Policy ID: Effective Date:

If Medicare, please check applicable type below:

Part A: ☐ Part B: ☐ Both: ☐

Signature: _____ Date: _____

Relationship (Please Circle): Self ☐ Spouse ☐ Child ☐

Other: _____