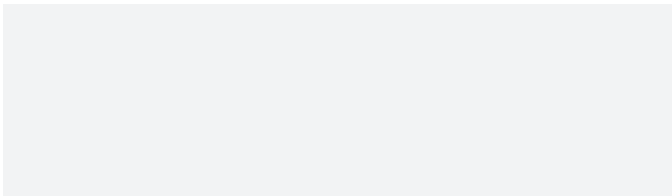
An Independent Licensee of the Blue Cross and Blue Shield Association

Coordination of Benefits Form



If you and your dependents have more than one health plan, completing this form will help us process your claims quickly and accurately. You can also complete this form online at hmsa.com. Go to Member Login and click Coordination of Benefits form in the Claims drop-down menu.

If you, your spouse, and your dependents are enrolled only in your HMSA plan, complete section 1.

If you, your spouse, or any of your dependents are enrolled in your HMSA plan and: Complete sections:

- ☐ Another health insurance plan .... 1 and 2
- ☐ Medicare .... 1 and 3
- ☐ Another health insurance plan and Medicare .... 1, 2, and 3

PLEASE PRINT

Section 1 – HMSA Subscriber Information

HMSA subscriber's name: ______________________ Birth date: ____________

Employment status: ☐ Active ☐ COBRA ☐ Retired Retirement date (if applicable): ____________

Employer's name: ______________________ Employer's phone no.: (_____)____________

Employer's address: ____

HMSA subscriber ID no.: ______________________ Social Security no.: __ __ __-__ __-__ __ __ __

Phone no.: (_________) ______________________

I certify that the information I've provided on this form is true and correct. I agree to inform HMSA of any changes.

HMSA subscriber's signature: ______________________ Date: ____________

Section 2 – Other Coverage Information

Policyholder's name: ______________________ Birth date: ____________

Sex: ☐ Male ☐ Female

Relationship to you: ______________________ Social Security no.: __ __ __-__ __-__ __ __ __

Other health plan's name: ______________________ Policyholder ID no.: ____________

Other health plan's address: ____

Phone no.: (_________) ______________________

Employment status: ☐ Active ☐ COBRA ☐ Retired Retirement date (if applicable): ____________

Employer's name: ______________________ Employer's phone no.: (_____)____________

Employer's address: ____

Type of coverage	☐ Medical	☐ Drug	☐ Dental	☐ Vision
Effective date				
Cancellation date				

2500-418300 10.21 cs

Please list any other dependents who are on the other plan.

1. First and last names: ______________________________
   Relationship to you: ______________________________
2. First and last names: ______________________________
   Relationship to you: ______________________________
3. First and last names: ______________________________
   Relationship to you: ______________________________
4. First and last names: ______________________________
   Relationship to you: ______________________________
5. First and last names: ______________________________
   Relationship to you: ______________________________
6. First and last names: ______________________________
   Relationship to you: ______________________________
7. First and last names: ______________________________
   Relationship to you: ______________________________
8. First and last names: ______________________________
   Relationship to you: ______________________________

Section 3 – Medicare Coverage Information

Medicare beneficiary's name:

____

Social Security no.:___ ___ ___-___ ___-___ ___ ___ ___

Medicare no.: ______________________________

Type of coverage	Effective date
Part A (Hospital)	
Part B (Medical)	
Part D (Drug)	

Medicare eligibility due to:

☐ Age

☐ Disability

☐ End-stage renal disease

- Initial dialysis date: ____________________

Medicare beneficiary's name:

____

Social Security no.:___ ___ ___-___ ___-___ ___ ___ ___

Medicare no.: ______________________________

Type of coverage	Effective date
Part A (Hospital)	
Part B (Medical)	
Part D (Drug)	

Medicare eligibility due to:

☐ Age

☐ Disability

☐ End-stage renal disease

- Initial dialysis date: ____________________

Please mail your completed Coordination of Benefits Form to:

HMSA
MS Primacy
P.O. Box 860
Honolulu, HI 96808-0860