PLEASE CALL YOUR INSURANCE COMPANY TO UPDATE YOUR COORDINATION OF BENEFITS

When we verified your child's insurance, we were asked by your insurance company to have the parent/guardian call and update their child's Coordination of Benefits. Your insurance company wants to know if there is any other insurance or to know if anyone else might be responsible for paying the medical claim. Your insurance company requires you, as the member, to update your COB every 12 months.

What is Coordination of Benefits?

COB is a provision used to establish the order in which health insurance plans pay claims when more than one plan might exist. When two or more health insurance plans cover the insured and dependents, one plan becomes the *primary* plan and the other becomes the *secondary* plan. For example, two working spouses have health insurance at their respective places of employment, and the child is covered by both insurances.

Why does this need to be done?

The claim for today's visit and all future visits will be held up by your insurance company and they will not process payment to the doctor until this is done. As a result of not updating your Coordination of Benefits, your insurance company will not process any claims and the balance would be applied to your financial responsibility.

The purpose of calling to update your COB is to identify/confirm whether or not there are multiple insurance coverage's and if so which plan would be primary. This is generally decided by the parents date of birth or court order.

What needs to be done?

On the back of your insurance card is a toll free number for members to call. Please use either a cell phone or our office phone (ask the front desk) and call the toll free number. Ask to either speak with a representative or follow the automated system to update the Coordination of Benefits. Write down the name of the person you are speaking with and/or the confirmation number that they provide you with at the end of the call.

Thank you in advance for partnering with us to insure your child's health care needs are met.

Child's Name: _____ DOB: _____

Representatives Name/Confirmation Number: _____

_____ Today's Date: _____
Parent's/Guardian Signature

Print Parent/Guardian Name: _____