



COORDINATION OF BENEFITS AND CLAIM INFORMATION FORM

CLAIMS DEPARTMENT
8170 33rd Avenue South, PO Box 1289
Bloomington, MN 55425-1289
www.healthpartners.com

To help expedite the processing of claims, please provide HealthPartners the following information about any other insurance you or your dependents may have. Mail your information to:

HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289

If you have any questions about Coordination of Benefits or this form, please call HealthPartners Member Services:

952-883-5000 or 1-800-883-2177

CLAIMS:
In most cases, your HealthPartners network providers will submit claims on your behalf. If you use an out-of-network provider or receive a bill that you think should be covered by your HealthPartners plan, please send itemized medical bills to:
HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289

HealthPartners Policyholder Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ HealthPartners Member # \_\_\_\_\_

I and/or dependents have claims for illness or injury that may be covered by:

- Other health insurance
No-fault insurance covering motor vehicle accident injuries
Workers' compensation covering work related illness or injury
Third-party liability covering injuries occurring on another person's or company's property

I have covered dependents and I have divorced or remarried:

Date \_\_\_\_\_ Signature \_\_\_\_\_

If you answered YES to any of the above, please fill out the reverse side of this form.

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**Section A Other Health Insurance Information**

Name of policyholder of other health insurance \_\_\_\_\_  
Date of birth of other insurance policyholder \_\_\_\_\_  
Name of other insurance company \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy/Group # \_\_\_\_\_ Effective date \_\_\_\_\_ Type of coverage: Single \_\_\_\_ Family \_\_\_\_

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**Section B No Fault Insurance Information**

Name of family member affected \_\_\_\_\_ Date of original injury \_\_\_\_\_  
Describe injury \_\_\_\_\_  
Name of affected family member's auto insurance carrier \_\_\_\_\_  
Carrier address \_\_\_\_\_ Carrier phone # \_\_\_\_\_  
Claim #, if known \_\_\_\_\_ Attorney, if retained \_\_\_\_\_ Phone # \_\_\_\_\_

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**Section C Workers' Compensation (Work. Comp.) Insurance Information**

Name of family member affected \_\_\_\_\_ Date of original injury \_\_\_\_\_  
Describe injury \_\_\_\_\_  
Name of affected family member's employer \_\_\_\_\_  
Name of affected family member's work. comp. carrier \_\_\_\_\_  
Work. comp. carrier address \_\_\_\_\_  
Work. comp. carrier phone # \_\_\_\_\_ Claim #, if known \_\_\_\_\_  
Attorney, if one has been retained \_\_\_\_\_ Phone # \_\_\_\_\_

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**Section D Third Party Liability Information**

Name of family member affected \_\_\_\_\_ Date of original injury \_\_\_\_\_  
Describe injury \_\_\_\_\_  
Name of person or establishment with financial responsibility for the injury \_\_\_\_\_  
Person/establishment address \_\_\_\_\_ Phone \_\_\_\_\_  
Attorney, if one has been retained \_\_\_\_\_ Phone \_\_\_\_\_

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**Section E Divorced and/or Remarried with Dependents Information**

Child's complete name	Name of person(s) with legal custody	Name and date of birth of person(s) responsible for dependent health-care expenses per divorce decree
_____	_____	_____
_____	_____	_____