Reset Form

Horizon Blue Cross Blue Shield of New Jersey

Coordination of Benefits

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Employee Information:

Patient Name: _____ _____ _____
Last First MI

Insured's I.D. Number: _____ Date: _____ / _____ / _____
MM DD YYYY

Home Address: _____

City: _____ State: _____ ZIP: _____

Coordination of Benefits

Is your Spouse or dependent employed? Yes ☐ No ☐

Is your Spouse or dependent retired? Yes ☐ No ☐

If answer is Yes, give Social Security Number: _____

Does your Spouse/Dependent have other health insurance? Yes ☐ No ☐

If yes, Spouse/Dependent Name with other Health Insurance _____

Spouse/Dependent Employer or Former Employer Name and Address _____

Name/Address and Phone Number of other Health Insurance Carrier _____

Group Policy ID Number(s) of other Health Insurance Carrier _____

Certification: I hereby certify that the information I have provided on this form is true and accurate. In the event any information is false or misleading, the plan administrator or employer may take appropriate action. In the event benefit payments are incorrectly or improperly made, I shall be fully responsible for repayment to the Plan of all costs, fees and expenses related to such improper or incorrect benefit payment, including a reduction in future payment of claims by the full amount of such improper or incorrect benefit payments.

Employee Signature: _____

Work Telephone Number: _____ – _____ – _____ Date: _____ / _____ / _____
MM DD YYYY

For Assistance Call 1-800-355-2583