Delta Dental of Washington

P.O. Box 75983 | Seattle, WA 98175-0983
(800) 554-1907 | www.DeltaDentalWA.com

Other Coverage Questionnaire

Subscriber Name _____

Subscriber Address _____

Subscriber Address _____

City, State, Zip Code _____

Member ID:
XXX-XX-XLast three of ID Number _____

Group Number:
Group # - Sublo _____

Service Date(s):
MM/DD/YYYY, MM/DD/YYYY _____

Claim Number: _____

Dear Subscriber:
Your dental plan, administered by Delta Dental of Washington , contains a coordination of benefits (COB) provision. By coordinating benefits with your other carrier, we may be able to reduce your out-of-pocket expenses for covered services. Please complete and return this form in the enclosed envelope. Please refer to the back of this form for answers to the most frequently asked coordination of benefits questions.

OTHER DENTAL INSURANCE INFORMATON:

Do you or any of your family members have any other dental coverage (including any other Delta Dental of Washington coverage)?

☐ **NO** - If no, please sign and return this form to Delta Dental of Washington

☐ **YES** - If yes, please complete the following:

1. OTHER INSURANCE INFORMATION:			
*Name of Policyholder:	*Policyholder's Member ID Number:	*Policyholder's Date of Birth: / /	Policyholder's Phone Number:
*Name of Insurance Company:	*Insurance Company Phone Number:	*Type of Coverage: ☐ Active ☐ Retirement ☐ COBRA	

*Who does the other coverage above apply to? *Include yourself if applicable*

Name (first and last)	*Coverage Effective Date	Term Date If COBRA	Name (first and last)	*Coverage Effective Date	Term Date if COBRA
1.	/ /	/ /	4.	/ /	/ /
2.	/ /	/ /	5.	/ /	/ /
3.	/ /	/ /	6.	/ /	/ /

(Attach additional pages if needed)

2. SUPPORT/CUSTODY INFORMATION:
If parents are divorced or legally separated, the following information is needed to comply with Washington State regulations pertaining to coordination of benefits **

Child's Name	Person with Custody (name and relationship)	Person with Health Care Responsibility (name and relationship)	Name of Other Carrier
1.			
2.			
3.			
4.			
5.			
6.			

* This information is required to complete the processing of your claim(s).
** If this is different from the Other Insurance Company listed in Question #1, please list all other coverage information (telephone number, name of policyholder, ID number, group number, etc.) on a separate sheet of paper.

Subscriber Signature: _____ Date: _____

DDWA USE ONLY	Do not write in this area	*03123-4-5123* (bar code)	Do not write in this area

Question and Answers to Help You Understand Coordination of Benefits

What is coordination of benefits (COB)?

Insurance companies working together to share the cost of dental care expenses when a person is covered under two or more group health plans.

Why do we coordinate benefits?

Insurance regulations allow dental care companies to coordinate benefits. These regulations allow us to keep your cost of dental care coverage as low as possible by avoiding payment of more than 100 percent of the total of claims submitted. The rules identify one plan as "primary" (the company that pays first) and the other plan as secondary (the company that pays second).

Who do I submit my claim(s) to first?

- If the patient is a Delta Dental of Washington subscriber, submit to us first and the other plan second.
- If the patient is the spouse of a Delta Dental of Washington subscriber, submit to the other plan first and to us second.
- If the patient is a dependent child, submit to the plan of the parent whose birthday falls earliest in the year. Example: If the mother's birth date is May 5th and father's birth date is November 9th, submit to the mother's plan first.
- If the parents of the patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage according to the divorce decree. If not stated in the divorce decree, submit claim(s) in the following order:
    1. To the plan of the parent with custody;
    2. To the plan of the spouse of the parent with custody;
    3. To the plan of the natural parent without custody; or
    4. To the plan of the spouse of the parent without custody.
- If you have two dental plans with Delta Dental of Washington, submit one claim with both subscriber's member identification numbers and group numbers.
- If you are the subscriber of more than one dental care plan, the coverage that has been effective the longest is primary. Submit your claim(s) to that carrier first.
- Retiree plans may require any non-retiree coverage to be primary.

How do we coordinate benefits?

- When Delta Dental of Washington receives your claim(s), we determine which dental care company will process your claim(s) first.
- If you submit your claim(s) with a copy of your other dental care company's denial or an explanation of benefits, we will use this information to process your claim(s) promptly.

When do I receive an "Other Coverage Questionnaire"?

- When we have conflicting, incomplete or outdated information.
- When your other coverage is cancelled, and we need new coverage information.

IMPORTANT REMINDERS

- When we request COB information, please return the form as soon as possible to assure prompt processing of your claim(s).
- Always keep your dental care providers updated with your correct dental care coverage information.