



## Instructions for Submitting Coordination of Benefits (COB) Questionnaire

***This form can be used to submit COB information on-line for all Texas groups with the exception of FEP (Federal Employees Program) members. A FEP member ID number begins with the letter 'R.' Since this group requires a member's signature, the form must then be mailed to P.O. Box 660044, Dallas, TX 75266-0044.***

**NOTE:** We offer this service as a courtesy to our physicians and providers on behalf of our members. This form must be completed with the member present.

1. Group and ID number is required on this form in order to update the member's COB information and to ensure correct and timely processing of claims.
2. Complete each section that is applicable to the member's coverage.
3. If Medicare is involved, please ensure a complete HIC number *including the alpha characters* is filled out in Section B of the COB questionnaire.
4. If there is no other insurance, please date, and return the questionnaire indicating "No other insurance."