ANTIDOTE

Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.

Member Coordination of Benefits Form

This form MUST be completed to notify Antidote Health of Medicare or other health insurance coverage for Coordination of Benefits (COB). Failure to complete this form will result in delays for claim payments.

Please return the completed form to: Attn: Member Services, Antidote Health Plan
PO Box 39638
Solon, OH 44139

You may also fax it to 1-216-504-9561 or securely email it to support@antidotehealth.com.

Section 1 – Member Contact Information

NAME OF MEMBER:	MEMBER ID:	DATE OF BIRTH:
ADDRESS:		
PREFERRED PHONE NUMBER:	EMAIL ADDRESS:	

Section 2 – Other Insurance Coverage

Do you or any family members on this health plan have other health insurance? ☐ Yes ☐ No If yes, please provide the following details.	
POLICYHOLDER'S NAME:	RELATIONSHIP TO MEMBER:
INSURANCE COMPANY NAME:	POLICY NUMBER/GROUP NUMBER:
EFFECTIVE DATE OF COVERAGE:	TYPE OF COVERAGE: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Other: _____ ☐ Medicaid ☐ Student Health Plan
EMPLOYER NAME, IF COVERAGE IS THROUGH EMPLOYER:	IS THIS COVERAGE STILL ACTIVE? ☐ Yes ☐ No
SUBSCRIBER STATUS: ☐ Active ☐ Retired ☐ On COBRA	DATE RETIRED, IF APPLICABLE:

Section 3 – Dependent Coverage

List the names of dependents covered under the other insurance plan.

NAME OF MEMBER:	DATE OF BIRTH:	RELATIONSHIP TO MEMBER:
NAME OF MEMBER:	DATE OF BIRTH:	RELATIONSHIP TO MEMBER:
NAME OF MEMBER:	DATE OF BIRTH:	RELATIONSHIP TO MEMBER:
NAME OF MEMBER:	DATE OF BIRTH:	RELATIONSHIP TO MEMBER:

Section 4 – Medicare Information (if applicable)

Are you or any dependents enrolled in Medicare ☐ Yes ☐ No If yes, please provide the following details.		
MEDICARE ID NUMBER:	PART A EFFECTIVE DATE:	PART B EFFECTIVE DATE:
MEDICARE ENTITLEMENT: ☐ Age ☐ Disability ☐ End State Renal Disease (ESRD)		
If the reason is disability, PLEASE PROVIDE THE FIRST DATE OF DISABILITY:		
If the reason is ESRD, PLEASE PROVIDE THE 1ST DATE OF DIALYSIS FOR ESRD:	WAS ESRD STARTED IN A FACILITY? ☐ Yes ☐ No WAS ESRD STARTED AS SELF DIALYSIS OR HOME DISALYSIS ☐ Yes ☐ No HAS A TRANSPLANT BEEN PERFORMED? ☐ Yes ☐ No IF YES, PLEASE PROVIDE THE DATE:	

Section 5 – Court Order Information

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? ☐ Yes ☐ No If yes, please provide the following details.		
NAMES OF DEPENDENTS THIS APPLIES TO:		
WHO IS THE PERSON(S) LISTED TO MAINTAIN HEALTH COVERAGE?	WHAT IS THE RELATION TO THE CHILD(REN)?	WHO HAS CUSTODY MORE THAN 50% OF THE TIME?

Section 6 – Signature and Authorization

SIGNATURE:	DATE:
DO WE HAVE YOUR AUTHORIZATION TO CONTACT THE OTHER INSURER FOR VERIFICATION? ☐ Yes ☐ No	