

SSN: _____ Date of Birth: _____ **LETTER CODE: 700**

Do (did) you or your participating dependents have other Medical, Pharmacy, Dental, Vision, Medicare or Medicaid coverage in **2020 and/or 2021**? YES NO

Please complete the form and refer to the letter for submission instructions.

OTHER INSURANCE INFORMATION (NON-MEDICARE) Please enclose a copy of the other insurance ID cards.

Policyholder's Name _____ Relationship to CC/AG Employee _____

Policyholder's Date of Birth ____/____/____ ID No. _____ Group No. _____

Original Effective Date ____/____/____ Policy Term Date (if applicable *) ____/____/____ ***Please provide a copy of Creditable Coverage Letter(s).**

Policy Obtained Through: Group Employment Individual Purchase Student Medicaid Other _____

Policy Status: Active Benefits Retiree Benefits COBRA **Policy Covers:** Medical Pharmacy Dental Vision

Policy Type: Employee Only Employee + Child/Children Employee + Spouse Family Other _____

Name of Other Insurance Company _____ Customer Service Telephone No. _____

Name of Employer _____

Please complete columns below for those covered under the other insurance policy listed above. Use additional COB forms if necessary.

Last Name	First Name	Date of Birth	Relationship	Effective Date	Term Date
_____	_____	____/____/____	_____	____/____/____	____/____/____
_____	_____	____/____/____	_____	____/____/____	____/____/____
_____	_____	____/____/____	_____	____/____/____	____/____/____
_____	_____	____/____/____	_____	____/____/____	____/____/____
_____	_____	____/____/____	_____	____/____/____	____/____/____

Is there legal documentation stating who is responsible for carrying the healthcare coverage for you or your dependents?
 YES NO **If yes, legal documents must accompany the form stating who is responsible for carrying healthcare coverage.**

Name of Custodial Parent _____

MEDICARE INSURANCE INFORMATION Please enclose a copy of your Medicare card.

Medicare ID No. _____

Medicare ID No. _____

Medicare Recipient Name _____

Medicare Recipient Name _____

Effective Date: Part A ____/____/____ Part B ____/____/____

Effective Date: Part A ____/____/____ Part B ____/____/____

Medicare Coverage is the result of:

Medicare Coverage is the result of:

Age (65 years)

Age (65 years)

Disability _____
Date Approved for Medicare Benefits

Disability _____
Date Approved for Medicare Benefits

End-Stage Renal Disease

End-Stage Renal Disease

If yes, please check one of the following:

If yes, please check one of the following:

Transplant _____
Date of Transplant

Transplant _____
Date of Transplant

Dialysis _____
Date of First Dialysis

Dialysis _____
Date of First Dialysis

Please check one: Home Dialysis Facility Dialysis

Please check one: Home Dialysis Facility Dialysis

CC/AG Employee Signature _____ **Date** ____/____/____

Ohio Revised Code Section 3999.21 – Insurance Fraud Warning "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."



CLEVELAND CLINIC/AKRON GENERAL EMPLOYEE HEALTH PLAN COORDINATION OF BENEFITS (COB) FORM

Coordination of Benefits (COB) is the process used to pay healthcare insurance policy expenses when you or an eligible dependent is covered by more than one healthcare insurance policy, including Medicare or Medicaid. If you/your dependents are covered by more than one healthcare insurance policy, Mutual Health Services (MHS), the Cleveland Clinic Employee Health Plan (EHP) Third-Party Administrator (TPA), follows rules established by Ohio law to decide which healthcare insurance policy pays first (primary plan) and the obligations of the other healthcare insurance policy (secondary plan). The combined payments of all healthcare insurance policies will not exceed the actual amount of your bills.

The following three options are available for submitting your COB information to MHS:

1. **Cleveland Clinic:** Complete the online COB form via the MHS website as follows: <https://chn.mutualhealthservices.com>.
OR You can access the website via the ONE HR Workday and Portal. Once you log in, click “ONE HR Portal,” then “ONE HR.” From the “My Health” drop down, click on “Medical Claims, RX & more”, then click the “Coordination of Benefits” tab in the Key Features bar. Click on “Mutual Health Services”. Sign in, and then click on “Health Plan Claims – Cleveland Employees Only.” Click on “Continue.” You will see the COB tab at the top.
Akron General: Complete the online COB form via the MHS website as follows: <https://chn.mutualhealthservices.com>.
OR Contact your HR Representative for assistance.

Please note: If you have legal documentation stating who is responsible for providing healthcare for the dependent children covered on your health plan, and/or you have other insurance in the current or prior plan year, then you may not submit your COB information via the web site. You may enter your COB information via the web site and then print and send it, along with your legal document, via mail or fax to MHS.

2. Complete the form, where applicable, then sign the bottom of the COB form, and return to MHS via Fax or U.S. mail.

Fax Number: Mutual Health Services
Administrative Service Department: 440-878-5487

Mailing Address: Mutual Health Services
Administrative Service Department
PO Box 89472
Cleveland, OH 44101-6472

Remember to include the following information (if applicable) for all parties on your EHP with your completed COB form:

- **Attach a copy of the other healthcare insurance ID card(s)**
- **Attach a copy of the Medicare card(s)**
- **Attach a copy of the certificate of creditable coverage for each person terminated on another healthcare insurance policy**

3. If no other insurance existed in the plan year being updated or the prior plan year, Call MHS Customer Service at 1-800-451-7929. The interactive voice response (IVR) system is available 24/7 to accept COB updates. A live, Customer Service Representative is available to personally assist you during regular business hours (Monday-Friday, 8am-5pm)

NOTE: Be advised that if you have other insurance and there is legal documentation regarding who is responsible for providing healthcare coverage for the dependent children on your health plan, then the legal documentation must accompany your COB information.

NOTE: Forms that are incomplete could be sent back for additional information and will delay the processing of your claim(s).

Multi-Language Interpreter Services & Nondiscrimination Notice



This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-451-7929 (TTY: 711).

Chinese

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-451-7929 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-451-7929 (TTY: 711).

Arabic

ملحوظة: إننا نقدم خدمات المساعدة اللغوية متوافر لك بالمجان. اتصل برقم 1-800-451-7929 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff. Call 1-800-451-7929 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-451-7929 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-451-7929 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-451-7929 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jik'eh, éí ná hóló, kojí' hódíilnih 1-800-451-7929 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-451-7929 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-451-7929 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-451-7929 (TTY: 711).

Japanese

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-451-7929 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-451-7929 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-451-7929 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-451-7929 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-451-7929 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Z8245-GHP R4/19

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-451-7929.

Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.