



**Children's Orthopedic  
Specialists**

THE ONLY PRACTICE DEDICATED TO PEDIATRIC ORTHOPEDICS IN SOUTHERN ARIZONA

## Coordination of Benefits for Other Insurance Coverage

◆ Indicates required fields

◆ **PATIENT NAME:** \_\_\_\_\_ ◆ **DATE OF BIRTH:** \_\_\_\_\_

◆ **NAME OF SUBSCRIBER:** \_\_\_\_\_ ◆ **PHONE#:** \_\_\_\_\_

◆ **Relationship to Patient:**  Self  Spouse  Parent  Other \_\_\_\_\_

◆ **Primary Insurance Subscriber ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

◆ **DOES THE PATIENT HAVE OTHER INSURANCE?**

**YES**      **IF YES, PLEASE FILL OUT SECTION I, SIGN AND DATE BELOW**

**NO**      **IF NO, SKIP SECTION I, SIGN AND DATE BELOW**

| <b>Section I - Other Health Care Coverage Information</b> |                          |
|---|--------------------------|
| ◆ Name of the Subscriber for the Other Insurance Policy   | Subscriber Date of Birth |
| ◆ Name of Other Insurance Carrier                         | ◆ Name of the Employer   |
| ◆ Policy Number   | ◆ Group Number           |
| ◆ Insurance Carrier Claim Address                         |                          |
| ◆ Insurance Carrier Phone Number                          |                          |
| ◆ Beginning Date of Coverage                              | ◆ End Date of Coverage   |

CERTIFICATION: I certify that the information I have provided is complete, true and correctly recorded to the best of my knowledge.

**Signature of Insured or Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Insured or Patient Name (print):** \_\_\_\_\_