Coordination of Benefits

Sutter Health Plus

When an individual has health coverage through two or more healthcare plans, the plans must work together to pay claims. This process is coordination of benefits.

You must complete this form if you, your spouse or your dependents are covered by Sutter Health Plus **and** another health plan or insurance company at the same time. Failure to provide true and complete information may result in delay or denial of claim payments.

Do not complete this form if other healthcare coverage ends when Sutter Health Plus coverage begins.

Email, fax or mail your completed form to:

EMAIL
shpenrollmentmailbox@sutterhealth.org

FAX
916-736-5426

MAIL
Sutter Health Plus
P.O. Box 160345
Sacramento, CA 95816

Section A – Sutter Health Plus Subscriber Information

Group Name | **Member ID #** | **Date of Birth**

Last Name | **First Name** | **MI**

Address | **City** | **State** | **ZIP**

Phone | **Email**

Section B – Other Healthcare Coverage and Subscriber Information

Other Health Plan/Insurance Company Name | **Group Policy #**

Other Health Plan/Insurance Company Address | **Coverage Effective Date** | **Coverage End Date**

Subscriber Last Name | **Subscriber First Name** | **Date of Birth** | **Subscriber ID #**

Type of Coverage

- ☐ COBRA
- ☐ Group
- ☐ Individual

Medicare (Check all that apply)

- ☐ Age 65+
- ☐ Part A
- ☐ Part A & B
- ☐ Part D
- ☐ Disabled
- ☐ End Stage Renal Disease

- ☐ Medi-Cal
- ☐ Other: _____

Sutter Health Plus
Your Health Plan

Section C – Other Healthcare Coverage Beneficiary Information

List all Sutter Health Plus members covered under the health plan/insurance company listed in Section B and their relationship to the subscriber of that plan. Include yourself, if applicable.

Beneficiary 1

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Beneficiary 2

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Beneficiary 3

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Beneficiary 4

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Beneficiary 5

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Beneficiary 6

Last Name	First Name	Date of Birth

Relationship to Subscriber
☐ Spouse/Domestic Partner ☐ Child ☐ Other _____

Other Health Plan/Insurance Company ID #

Section D – Sutter Health Plus Subscriber Signature

By signing this form, I declare that the information I have provided is true and complete. I understand that if benefit payments are incorrectly or improperly made, I shall be fully responsible to Sutter Health Plus for repayment of all costs, fees and expenses related to such payments. Further, I understand that to the extent permitted by law, Sutter Health Plus may deny benefits and retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility.

_____ _____

Sutter Health Plus Subscriber Signature **Date**