

Coordination of Benefits

Sutter Health Plus

When an individual has health coverage through two or more health care 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 health care 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 (SHP) Subscriber Information

Group Name	SHP Member ID #	Date of Birth	
Last Name	First Name	MI	
Address	City	State	ZIP
Phone	Email		

Section B – Other Health Care 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: _____

Section C – Other Health Care 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.

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Sutter Health Plus Subscriber Signature

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Date