FOUNDATION FOR MEDICAL CARE
OF TULARE & KINGS COUNTIES, INC

Return completed forms to:
Foundation for Medical Care
3335 S Fairway
Visalia, CA 93277
OR Fax: 559-468-3140

COORDINATION OF BENEFITS QUESTIONNAIRE

For your convenience, you can email your coordination of benefits information to kaweahcobform@tkfmc.org.
If neither you nor your covered dependents have any additional health coverage, simply call our automated response number at 559-802-1995.

SECTION 1 YOUR FOUNDATION INFORMATION

Foundation enrollee name (as found on your ID card)	Foundation Enrollee ID/Contract Number

In addition to this Foundation contract, are you or any of your covered dependents also covered by another group health care plan other than Medicare?

☐ NO — Please skip the rest of the questions, sign at the bottom ☐ YES — Please complete entire form, sign at the bottom and return

SECTION 2 OTHER HEALTH CARE COVERAGE

Please provide the following information about the policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

Enrollee ID / policy number	Group number	Effective date	Cancellation date

Type of Coverage
Single Family

Is this a retiree contract? ☐ Yes ☐ No
Is this a COBRA contract? ☐ Yes ☐ No
Is this policy holder laid-off? ☐ Yes ☐ No

Type of Plan:
(Check all that apply) ☐ Hospital ☐ Medical ☐ Dental ☐ Drugs

Who is covered by this other plan? (Include yourself if applicable)

	Name (first and last)	Relationship to you		Name (first and last)	Relationship to you
1.			4.		
2.			5.		
3.			6.		

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation, etc.

Is there a court order that determines responsibility for health care coverage or custody? ☐ No ☐ Yes - (attach a copy of the sections that apply to health care responsibility and/or/ custody arrangements)

Name of person responsible for child's health care coverage	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

Enrollee ID / policy number	Group number	Effective date	Cancellation date

Which children are covered by this insurance?

	Child's name (first and last)	Who has custody		Child's name (first and last)	Who has custody
1.			4.		
2.			5.		
3.			6.		

SECTION 4 MEDICARE COVERAGE

Do you and/or another family member have Medicare? If yes, provide the following for each family member with Medicare?

Name of Medicare beneficiary	☐ Medicare A ☐ Medicare B ☐ Both

Medicare member ID	Entitlement reason ☐ Age ☐ Disability ☐ End stage renal disease	Effective date

If entitled due to end stage renal disease, please provide:

The date of first dialysis: ☐ Home dialysis ☐ Dialysis in facility/dialysis center | Date of transplant, if applicable:

NOTE: PLEASE DON'T RETURN THIS FORM WITHOUT A VALID SIGNATURE AND DATE.

Signature:	Date: