Coordination of Benefits

Sutter Health Plan

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 Plan **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 Plan coverage begins.

Email, fax or mail your completed form to:

EMAIL
shpserviceteam@sutterhealth.org

FAX
916-736-5426

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

Section A – Sutter Health Plan 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 Plan

Section C – Other Healthcare Coverage Beneficiary Information

List all Sutter Health Plan 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	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Beneficiary 2

Last Name	First Name	Date of Birth

Relationship to Subscriber	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Beneficiary 3

Last Name	First Name	Date of Birth

Relationship to Subscriber	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Beneficiary 4

Last Name	First Name	Date of Birth

Relationship to Subscriber	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Beneficiary 5

Last Name	First Name	Date of Birth

Relationship to Subscriber	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Beneficiary 6

Last Name	First Name	Date of Birth

Relationship to Subscriber	Other Health Plan/Insurance Company ID #
Spouse/Domestic Partner Child Other ________	

Section D – Sutter Health Plan 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 Plan for repayment of all costs, fees and expenses related to such payments. Further, I understand that to the extent permitted by law, Sutter Health Plan may deny benefits and retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility.

____ ____________________

Sutter Health Plan Subscriber Signature **Date**