



The Austin Diagnostic Clinic
 Allergy & Immunology Department
 Offices in North Austin, South Austin
 and Round Rock

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www.adclinic.com/allergy

Coordination of Benefits Questionnaire

Insured Name: _____
 Insured ID #: _____
 Pt. Name: _____ Relationship: _____

Please take a moment to respond to the following questions:

I. Do you or any member of your family have other group insurance?
 YES _____ NO _____

Do you or any of your family members have a Medicare policy?
 YES _____ NO _____

II. If yes, please provide the following information, (sign and return). Please include any other health insurance coverage provided by a natural parent as established by a divorce, decree, etc.

1. Primary Insured: _____
 Date of Birth: _____

2. Other Insurance Company's Name: _____
 Address: _____

3. Effective Date of Policy: _____

4. Policy ID #: _____

5. List any members covered under the above-mentioned health insurance (please include full name, date of birth, relationship, and sex.):

NAME: _____
 DOB: _____
 REL: _____
 SEX: _____

NAME: _____
 DOB: _____
 REL: _____
 SEX: _____

III. If you have Medicare Part A or B please answer the following questions:

NAME: _____

ID: _____

Medicare A effective date: _____

Medicare B effective date: _____

Are you retired, disabled, or actively working? _____

Retirement Date: _____

Disability Date: _____

If a dialysis patient, what was the first treatment date? _____

Thank you for your cooperation.

 Signature/Date