# Maternity Insurance Dual Coverage Coordination of Benefits (COB) Form

## Member Information

Member Name

Member ID

Date of Birth

Phone Number

Address

## Other Insurance Information

Is patient covered by another insurance?

Other Insurance Company

Policy Number

Group Number

Effective Date

Policyholder Name

Relationship to Patient

Policyholder Date of Birth

## Employer Information

Employer Name

Employer Address

## Dependent Information (if applicable)

| Name | Date of Birth | Relationship | Covered by Other Insurance |
|---|---|---|---|
| | | | |
| | | | |

## Maternity Details

Expected Delivery Date

Obstetrician/Provider Name

## Authorization

Signature

Date