Scripps | Scripps Health Plan

Dear Subscriber:

In order to properly process claims for your benefits, Scripps Health Plan asks members to complete a **Coordination of Benefits (COB**) form every year. This form allows you to provide information about whether you, your spouse or your eligible dependents are covered under more than one health plan. The information you provide allows Scripps Health Plan to comply with State & Federal laws that mandate the order of payment responsibility.

If you and/or your dependents **DO NOT** have other health insurance coverage, simply check the box below, sign and return this form **within 30 days** to ensure timely and accurate processing of claims by Scripps Health Plan.

If you and/or your dependents **DO** have health insurance coverage under another health plan please complete this questionnaire. Please return this form **within 30 days** to ensure timely and accurate processing of claims by your health plan(s).

Do you, your spouse or any dependents have other health insurance coverage?

□ YES □ NO

If you answered **NO** to having other health insurance coverage, please sign and date the form and return to Customer Service

MEMBER VERIFICATION I hereby verify that the above information is true, complete and accurate to the best of my knowledge.	
Subscriber's Signature	Date (MM/DD/YYYY)
Print Subscriber's Name	Subscriber/Member #

You may respond to this request by using one of these options:

1. Provide the information by **phone** by contacting Scripps Health Plan HMO Customer Service at **(844) 337-3700,** or for the hearing and speech impaired **TTY: 1-888-515-4065;**
2. Send via **facsimile** to Customer Service at **(858) 964-3102**;
3. Send via **email** to Customer Service at customerservice@scrippshealth.org
4. Return the form by **mail** to Scripps Health Plan HMO Customer Service, 10790 Rancho Bernardo Rd. 4S-300, San Diego, CA 92127

If you answered **YES** to having other health insurance coverage, please complete page 2 of this COB form.

SHP COB v6 02 11 2020

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Please provide the below **required** information about **YOUR** other coverage:

Name of Other Insurance Carrier (please print)	Insurance Carrier Phone Number	Plan Effective Date (MM/DD/YYYY)
Type of Medical Plan: □ HMO □ PPO □ EPO □ POS □ Other _____	Type of Plan: □ Group (employer benefit) □ Retiree □ COBRA □ Medicare □ Medi-Cal □ Medicaid □ Other _____	
Subscriber's Name (please print)	Date of Birth (MM/DD/YYYY)	Member ID Number
Subscriber's Employer *(if applicable)*	Employer Group Number	

If your covered dependent(s) has other health coverage, complete the fields below:

Dependent's Name (please print)	Date of Birth (MM/DD/YYYY)	Relation to Subscriber: □ Spouse □ Child
Name of Other Insurance Carrier (please print)	Insurance Carrier Phone Number	Plan Effective Date (MM/DD/YYYY)
Type of Medical Plan: □ HMO □ PPO □ EPO □ POS □ Other _____	Type of Plan: □ Group (employer benefit) □ Retiree □ COBRA □ Medicare □ Medi-Cal □ Medicaid □ Other _____	
Subscriber's Name (please print)	Date of Birth (MM/DD/YYYY)	Member ID Number
Subscriber's Employer *(if applicable)*	Employer Group Number	

If you need additional space to provide information, simply attach a separate page with this form.

If the other coverage is Medicare, please provide the following information:

Subscriber's Name (please print)	Medicare HIC Number	Plan Effective Date (MM/DD/YYYY)
Why does this member have Medicare?	□ Age 65+ □ Disability	□ End Stage Renal Disease
If this member is receiving dialysis, when was the first date of treatment (MM/DD/YYYY):	Where does this member receive dialysis? □ Home □ At a Dialysis Facility □ Other _____	

Please sign and date the form and return to Scripps Health Plan using one of the options outlined on page 1.

MEMBER VERIFICATION I hereby verify that the above information is true, complete and accurate to the best of my knowledge.	
Subscriber's Signature	Date (MM/DD/YYYY)
Print Subscriber's Name	Subscriber/Member #

Customer Service (844) 337-3700 | TTY (888) 515-4065 |Fax (858) 964-3102 | www.ScrippsHealthPlan.com
10790 Rancho Bernardo Rd. 4S-300 San Diego, CA 92127

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Nondiscrimination Notice & Language Access

In addition to the State of California nondiscrimination requirements, Scripps Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scripps Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, ancestry, marital status, gender, gender identity, sexual orientation, or sex. To assist members in accessing services, Scripps Health Plan:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    a) Qualified sign language interpreters
    b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

2. Provides free language services to people whose primary language is not English, such as:
    a) Qualified interpreters
    b) Information written in other languages

If you need these services, contact Scripps Health Plan Customer Service by calling 1-844-337-3700 (TTY: 1-888-515-4065).

If you believe that Scripps Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, ancestry, marital status, gender, gender identify, sexual orientation or sex, you can file a grievance to the Plan Compliance Officer or the Appeals and Grievance Department by mail, in person, telephonically, fax, email or online. If you need help filing a grievance, we are available to help you.

a) Mail or in person:
Scripps Health Plan ATTN: Appeals & Grievances
10790 Rancho Bernardo Rd. Mail Drop 4S-300
Rancho Bernardo, CA 92127

b) Phone: 1-844-337-3700 (TTY: 1-888-515-4065)

c) Fax: 1-858-260-5879

d) Email: SHPSAppealsAndGrievancesDG@scrippshealth.org

e) Online: www.scrippshealthplan.com

If your health problem is urgent, you already filed a complaint and are not satisfied with the decision, or it has been more than 30 days since you filed a complaint, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the **DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or phone at:

Scripps | Scripps Health Plan

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish (Español)

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-337-3700** (TTY: **1-888-515-4065**). Scripps Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Chinese (中文)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-337-3700 (TTY **1-888-515-4065**）。Scripps Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Vietnamese (Tiếng Việt)

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-844-337-3700** (TTY: **1-888-515-4065**). Scripps Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-337-3700** (TTY: **1-888-515-4065**). Sumusunod ang Scripps Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Korean (한국어)

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-844-337-3700** (TTY: **1-888-515-4065**) 번으로 전화해 주십시오. Scripps Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Armenian (հայերեն)

Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-844-337-3700** (TTY (հեռատիպ)՝ **1-888-515-4065**): Scripps Health Plan-ը հետևում է քաղաքացիական իրավունքների մասին գործող դաշնային օրենքներին և խտրականություն չի ցուցաբերում՝ ռասայի, մաշկի գույնի, ազգային պատկանելության, տարիքի, հաշմանդամության կամ սեռի հիման վրա:

Persian (Farsi) فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 1-888-515-4065) 1-844-337-3700 تماس بگیرید.

Scripps Health Plan از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

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Russian (русском)

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-337-3700** (телетайп: 1-888-515-4065). Scripps Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Japanese (日本)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-844-337-3700**（TTY: 1-888-515-4065）まで、お電話にてご連絡ください。Scripps Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Arabic (العربية)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-337-3700 (رقم هاتف الصم والبكم: 1-888-515-4065). يلتزم Scripps Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Punjabi (ਪੰਜਾਬੀ ਦੇ)

ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-844-337-3700** (TTY: **1-888-515-4065**) 'ਤੇ ਕਾਲ ਕਰੋ। Scripps Health Plan ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਹੱਕਾਂ ਦੇ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜਾਂ ਲਿੰਗ 'ਤੇ ਅਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦੀ ਹੈ।

Mon Khmer (ខ្មែរ)

បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ **1-844-337-3700** (TTY: **1-888-515-4065**)។Scripps Health Plan អនុវត្តតាមច្បាប់សិទ្ធិពលរដ្ឋនៃសហព័ន្ធដែលសមរម្យនិងមិនមានការរើសអើស លើមូលដ្ឋាន នៃពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទ។

Hmong (Hmoob)

Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-844-337-3700** (TTY: 1-888-515-4065). Scripps Health Plan ua raws cov kev cailij choj yuam siv ntawm Tsom Fwv Nrub Nrab Teb Chaw hais txog pej xeem cov cai (Federal civil rights laws) thiab tsis ciav-cais leejtwg vim nws hom neeg, nqaij tawv, lub tebchaws tuaj, hnub nyoog, kev tsis taus, los yog poj niam txiv.

Hindi (हिंदी)

यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-844-337-3700** (TTY: **1-888-515-4065**) पर कॉल करें। Scripps Health Plan लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Thai (ไทย)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-844-337-3700** (TTY: **1-888-515-4065**). Scripps Health Plan ได้ปฏิบัติตามรัฐบัญญัติด้านสิทธิ์ที่เหมาะสม และไม่ได้แบ่งแยกทางชาติพันธุ์ สีผิว เชื้อชาติ อายุ ความทุพพลภาพ หรือเพศ