



MHBP Coordination of Benefits Form

We Want to Be Ready to Handle Your Claims...

You can't always know just when you or your family will need medical treatment. But you can take steps now to help make sure things go smoothly. Even if your physician files claims for you, we need to know if you or your dependents have additional health care coverage. We cannot pay any claims until we have this information from you—**please provide it as soon as possible**. You can provide it over the phone, or you can complete and return this form to the address below. If any of this information changes in the future, you should advise us immediately. **Please call [1-833-497-2416](tel:1-833-497-2416) (TTY: [711](tel:711)).**

Enrollee Information	
Please Print Your Full Legal Name Below (Avoid nicknames and abbreviations, Include title (Jr., Sr., III., etc.) with first name)	
Enrollee Name (Last, First, Middle Initial)	
Enrollee MHBP PSHB ID number	
Birthdate (MM/DD/YY)	Is there a court decree that declares which parent is to provide coverage for any of your covered dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Coverage Information	
Are you or any dependents (including spouse) covered under another health plan or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No; Skip this section. Simply sign and date.	
Other Plan Information	
Name of Enrollee (Last, First)	
Effective Date of Other Insurance Coverage	
Enrollee's ID Number	Relation to Above Enrollee <input type="checkbox"/> Enrollee (self) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Name of Person(s) Covered (Last, First)	
Name of Other Insurance or Medicare	Benefit Type(s) (check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription
<p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</p> <p>I hereby certify that the above information is correct to the best of my knowledge.</p>	
Enrollee Signature	Date

Please submit this form to: **MHBP Postal Service Benefits Plan**
PO Box 981106
El Paso, TX 79998

All benefits are subject to the definitions, limitations and exclusions set forth in the official Plan brochure (RI 71-023).

