POTOMAC RADIATION ONCOLOGY CENTER
A SERVICE OF INOVA AND SENTARA HEALTHCARE

1COB

Complete a health insurance section for each of your health plans/coverages.

Health Insurance - 1

Subscriber Name: _____ Subscriber Date of Birth: _____

Name of Health Insurance Company: _____

ID/Policy Number: _____ Group Number: _____ Effective Date of Policy: _____

Patient Relationship to Subscriber: _____

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: _____

Does patient have additional health insurance or Medicare:

☐ Yes. If yes, please complete corresponding sections, sign, print name and date.

- Health insurance - complete box 2
- Medicare – complete box 3

☐ No. If no, please sign, print name and date.

If you have an additional plan/coverage, please complete the box below.

Health Insurance - 2

Subscriber Name: _____ Subscriber Date of Birth: _____

Name of Health Insurance Company: _____

Address of Health Insurance Company: _____

ID/Policy Number: _____ Group Number: _____ Effective Date of Policy: _____

Patient Relationship to Subscriber: _____

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: _____

If you have Medicare, please complete the box below.

Medicare - 3

Medicare Number _____

Hospital (Part A) Effective Date _____ Medical (Part B) Effective Date _____

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease

If Disability: Date Disability Began: _____

If End Stage Renal Disease: Date of First Dialysis: _____ Kidney Transplant Date _____

Are you Currently Employed? ☐ Yes ☐ No If no, Date of Retirement: _____

Patient/Parent/Legal Guardian (signature): _____ Date: _____

Patient/Parent/Legal Guardian (print name): _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ◯ Male ◯ Female

Inova

Coordination of Benefits Questionnaire

CAT # 20524DT/R110717 • PKGS OF 100