Vibra Health Plan
PO Box 60250
Harrisburg, PA 17106-0250

Coordination of Benefits

Dear Valued Member,

If you are covered by more than one medical, prescription drug or dental health plan, Vibra Health Plan coordinates benefits with other insurers to help you receive the full benefit of those plans. By coordinating benefits, we may be able to reduce your out-of-pocket expenses for covered services.

We request information regarding other insurance upon your initial enrollment and on an annual basis for verification of any changes that may have happened during the year. In order to prevent your claim from being delayed or denied, please take a moment to complete this form and return it to us within 10 days in the enclosed postage paid envelope. If you need help or have any questions, please contact our Member Services department at 844-388-8268, (TTY dial 711), 8 am to 8 pm, 7 days a week.

Please let us know if you or any family members have any other medical, prescription drug or dental coverage. Please attach a separate sheet for any additional plan information.

Please type or print legibly in ink, completing all information requested and sign in Section 4. Thank you!

Member name	Member ID

Section 1 › Other medical insurance

Is there other medical insurance? ☐ Yes (*If yes, complete the section below)* ☐ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type ☐ Retiree ☐ COBRA ☐ Individual ☐ Other (please specify):		
Employer Group name:		Employer Group Number:

Section 2 › Other prescription drug insurance

Is there other prescription drug insurance? ☐ Yes (*If yes, complete the section below)* ☐ No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date

Other insurance carrier	Other carrier's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type ☐Retiree ☐COBRA ☐Individual ☐Other (please specify):		
Rx Group Number:	Rx BIN:	Rx PCN:

Section 3 › Other dental insurance

Is there other dental insurance? ☐Yes (*If yes, complete the section below)* ☐No

Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Other carrier's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type ☐Retiree ☐COBRA ☐Individual ☐Other (please specify):		

Section 4 › Authorization

We appreciate the time you have taken to complete the information on this form.

Your signature below certifies that the information you have entered on this form is true and correct to the best of your knowledge.

You agree to contact us immediately should changes occur with any of your coverage.

Signature of member	Date
Daytime phone of member	Email of member