

**The Jungle Gym Rehabilitation Center for Children**

*“Where therapy is play”*

**Coordination of Benefits Questionnaire**

Patient Name: Date of Birth:

**A.** Within the past year, has the patient been covered by any other insurance company?

(Check the box that applies)

􀂉 **No.** (Skip Part B)

􀂉 **Yes.** (Please complete the remainder of this questionnaire.)

**B.** Please indicate other insurance details

􀂉 **Another health insurance**

Name of other health insurance company:

Name of other employer:

Address where claims are submitted:

Insurance Phone Number:

Name of Policyholder:

Policyholder’s date of birth (month, day, year):

Policyholder’s ID #:

Effective date of policy (month, day, year):

Cancellation date, if applicable (month, day, year):

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Printed Parent/Guardian Name:

Signature of Parent/Guardian:

Date Signed:

We thank you for the time spent completing this questionnaire.

The information provided will help to avoid claims being pended for processing.