

CLAIM FORM TO BE COMPLETED BY STUDENT

School Name: WESTERN KENTUCKY UNIVERSITY STUDY ABROAD PLAN Policy # GLMN04849115

1. Student Name: _____ Social Security Number _____ - _____ - _____

2. Mailing Address: _____

Number Street City State Zip

3. Permanent Address: _____

Number Street City State Zip

4. Date of Birth ____/____/____ Local Phone (____) _____ Home Phone (____) _____

5. Patient Status: Male Female Single Married

6. Is this a claim for a dependent? Yes No If yes, give name _____

Relationship _____ Date of Birth ____/____/____

7. Name of physician _____ Date of Initial Service ____/____/____

8. Description of illness or injury _____

9. Has the patient been treated for the above condition(s) in the last 6 months? Yes No

If yes, give condition(s) treated for and date (s) of treatment _____

10. Is this claim the result of an accident? Yes No If yes, give date of accident ____/____/____

Where did the accident occur? _____

How did the accident happen? _____

11. Is this claim the result of a work-related injury? Yes No

12. Is this claim the result of intercollegiate sports? Yes No

13. Is patient covered for benefits (other than this policy) by any of the following:

Yes No Any Individual, Blanket or Short Term Medical Insurance?

Yes No Group Health Benefits of any kind through an employer, spouse's employer, or parent's employer?

Yes No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

If any of the above apply, please complete the following:

Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____

Name Relationship

Insurance Co. or Benefit Plan _____ Sponsor or Employer _____

Insurance Co. Address _____ Sponsor Address _____

Telephone (____) _____ Plan/Group Number _____ Sponsor Telephone (____) _____

If Blue Cross, show Group and Certificate No. from Blue Cross ID Card _____

Group # Certificate #

14. Is patient covered under MEDICARE (please mark all that apply): Part A Part B Not Covered

If covered, give effective dates: Part A: Mo. ____/Day ____/Year ____ Part B: Mo. ____/Day ____/Year ____

15. Is patient related to the provider of services? Yes No If yes, state the relationship _____

16. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested with respect to this claim.

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

Date ____/____/____ Signature of Student _____

Date ____/____/____ Signature of Patient _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to any provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Date ____/____/____ Signature _____

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM FORM:

1. An initial claim is being submitted for each Covered Person.
2. A new claim is being submitted for a completely different illness or injury for each Covered Person.

HOW TO FILE A CLAIM:

1. Complete the applicable items on the reverse side.
2. Promptly mail this form with any itemized bills to HealthSmart.
3. If you receive additional bills on this claim after you have mailed this form, it is not necessary to complete another form.
4. Identify bills by adding the following information:
 - School's Name and Policy Number
 - Student's Name and Social Security Number
 - Patient's Name and address

MAIL ALL CLAIMS TO:

HealthSmart
3320 W. Market St., Suite 100
Fairlawn, OH 44333
(800) 331-1096

Please remember to always make a copy of your claim forms and prescription receipts before mailing to our office.