3320 West Market Street, Suite 100
Fairlawn, OH 44333
(800) 331-1096

LONE STAR COLLEGE SYSTEM
2015-2016 TRAVEL ABROAD INSURANCE

CLAIM FORM

TO BE COMPLETED BY EMPLOYEE/STUDENT

School Name: **LONE STAR COLLEGE SYSTEM**____________________ **Policy #** **GLMN11086925R**

Employee/Student ID Number____________________

1. Employee/Student :____________________
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 Employee/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 or email this form with any itemized bills to HealthSmart.
3. If you receive additional bills on this claim after you have mailed or emailed this form, it is not necessary to complete another form.
4. Identify bills by adding the following information:
   - School's Name and Policy Number
   - Employee/Student Name and ID 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.