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

WESTERN KENTUCKY UNIVERSITY
2016-2017 STUDY ABROAD PLAN
STUDENT HEALTH INSURANCE PLAN

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:

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