

# Student Medical Insurance Plan Claim Form

Student Health Center · Student Medical Insurance Office

Mailcode 6740 · 374 East Grand Avenue · Carbondale, IL 62901

Ph: 618-453-4413

Claim form spring 2006

## IMPORTANT - YOUR CLAIM WILL BE DENIED IF THIS FORM IS NOT FULLY COMPLETED

Name of the student (Last, First, MI)	Social Security Number	Date of Birth	Age
Permanent home address (Number, Street, City, State, and ZIP Code)		Permanent home phone #	
Local home address (Number, Street, City, State, and ZIP Code)		Local phone #	

### Injury or condition

Describe injury or condition	
When did symptoms first appear or accident happen Date: ___/___/___ Time _____	If pregnant, state first day of last menstrual period
If injury, describe how and where accident occurred - give complete details (use additional pages if necessary)	
If a motor vehicle injury, list names of all drivers and companies insuring all drivers and/or vehicles	If injured during practice or play of sports, what sport was involved? Check One: <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate athletics <input type="checkbox"/> Other
Have you suffered the same or similar condition before <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates of prior medical care for this condition From: ___/___/___ To: ___/___/___
Name and address of attending physician(s)	Name and address of hospital/clinic

### Other insurance

Do you have any other insurance - group, individual, or through your parent(s), guardian, or spouse?

No  Yes, **If Yes give the following data**

Name of the company	Name of policy holder	I.D. number
Company address	Father's name	
Company Phone #	Mother's name	
Group number	Father's employer's name and address	
Policy number	Mother's employer's name and address	

### DISCLOSURE OF AUTHORIZATION (Patient/student's responsibility to complete)

I understand this form must be completed and returned with six months from the date of onset illness/injury to the Student Medical Insurance Office accompanied by all bills incurred to that date. I understand that failure to fully complete the information requested herein will result in permanent denial of my claim. Upon presentation of the original copy of this signed authorization, I authorize any medical, health care professional, hospital, clinic, or other medical or medically related facility, government agency, parents, guardian, or spouse or other person or firm to provide information including but not limited to copies of bills and records, concerning advice, care or treatment provided to me including, without limitation, information relating to mental illness, use of drugs or alcohol, or insurance coverage, to Southern Illinois University Carbondale representatives involved in evaluating, determining or administering claims for medical benefits for me. I understand that I will receive a copy of this authorization upon request. This authorization is valid from date signed through the term coverage of the policy or during the period to process the claims. This authorization may be revoked, in writing, but such revocation may affect my right to coverage.

Name / Title (print)

Signature

Date