HealthSmart

MEDICAL CLAIM FORM

Student Information

Student Name: _____ Student ID Number: _____
(Last) (First) (Middle Initial)

(School) Student Street Address _____

(School) City, State & Zip _____

(Home) Student Street Address _____

(Home) City, State & Zip _____

Claim is for (please check one):

___***Student*** ___ ***Student's Spouse*** ___ ***Student's Child*** _____
(Name)

___**Yes** ___**No** Is patient covered for benefits (other than this policy) by any Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:

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

_____

(Name) (Relationship)

Insurance Company Benefit Plan _____Plan/Group Number _____

Insurance Company Address_____ Telephone (_____)_____

Is this claim the result of an accident? ___**Yes** ___**No** If yes, give date of accident (MM/DD/YY) ___/___/_____

Please provide accident details, how, when and where:

_____

_____

_____

Student Authorization

PLEASE READ AND SIGN. I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself and/or dependents. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X _____ Date (MM/DD/YY) ___/___/_____