Student Insurance Claim Form

Upon completion, send this form to:

Consolidated Health Plans, Inc.
2077 Roosevelt Ave
Springfield, MA 01104
Fax (413) 733 - 4612

School Name:		
Student Name:	Member ID Number:	Date of Birth:
Student Address* City State Zip		
Email:	Telephone:	

***Note: All address changes must be done through your plan sponsor.**

Is this claim for your dependent? ☐ YES ☐ NO

Dependent's Name:_____ Date of Birth: _____

Do you, your dependents, or your parents have any other insurance or medical plan that covers this condition? ☐ YES ☐ NO

If yes, please enter the name of the insurance company: _____

1. **For an Annual/Routine Examination:** ☐ YES ☐ NO
2. **For an Illness/Prescription:**

Please describe symptoms: _____

Date of illness: _____

Date you first consulted a physician for this illness: _____

Have you ever sought treatment for this illness in the past: ☐ YES ☐ NO

If yes, please describe past treatment and dates: _____

_____

_____

3. **For an Injury:**

Please describe how injury occurred: _____

_____

Where did the injury occur (home, work, etc)_____

_____

Date of injury: _____

What body part was injury (include right or left if applicable)_____

Was the injury a result of an auto accident? ☐ YES ☐ NO

Were you injured while working on the job? ☐ YES ☐ NO

Were you injured during practice or play of an intercollegiate sport? ☐ YES ☐ NO

If yes, signature of athletic director: _____

Have you ever sought treatment for this injury in the past? ☐ YES ☐ NO

If yes, please describe past treatment and dates: _____

Were you treated by Student Health Services and referred for this condition? ☐ YES ☐ NO

Seen by: _____

If not referred, why? _____

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Consolidated Health Plan or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just a valid as the original. I authorize Consolidated Health Plans or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

_____ _____

Signature of Claimant Date