National Union Fire Insurance Company of Pittsburgh, Pa.

MAIL TO:
First Health
P.O. Box 7820
London, KY 40742
1-888-622-6001

CLAIM FORM

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

COVERAGE VERIFIED

PLEASE PRINT ALL INFORMATION

SPECIAL NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MUST BE COMPLETED AND SIGNED

Name of School	Policy Number	Birth Date
WASHINGTON COLLEGE	CHH0084485	

Insured's Name _____
LAST NAME | FIRST NAME | M.I | INSURED'S STUDENT ID # | PHONE

Present Address _____
NO. AND STREET | CITY OR TOWN | STATE | ZIP + 4

Home Address _____
NO. AND STREET | CITY OR TOWN | STATE | ZIP + 4

If claim for dependent, give dependent's name _____, relationship to insured _____ D.O.B. _____

MUST BE COMPLETED

Are you covered (as an insured or dependent) by any other hospital and/or medical plan? ☐Yes Insured ☐Yes Dependent ☐No

If yes, please check one: ☐Group ☐Individual ☐Automobile/Medical

If yes, also indicate name and policy number of insurance company.

Name of Insured: _____ Policy #/Group #: _____ I.D. # _____ Company _____

Have you filed a claim with the above company? ☐Yes ☐No

Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.

Name and Address of Employer of:

☐Insured, if employed _____

Spouse, if insured is married _____

1. Date of accident or sickness		Date of first treatment.	
2. Nature of sickness or injury.			
3. If injury, describe how and when accident occurred and indicate if work related			
*4. If injured in practice or play or sport, indicate which sport.		Check One:	☐Intramural ☐Intercollegiate ☐Other
5. Have you previously been troubled with this condition?	☐Yes ☐No Date _____		
6. Give name of all other physicians consulted			
7. Hospitalized? If so, where and what dates	Where?	From: _____ To: _____	
8. Health Center referral?	☐Yes If yes, attach referral to claims form. ☐No If no, please explain _____		

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician and others), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED

*** IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL**

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision

Signature of College Official _____ **Title** _____ **Date** _____

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one or which will be given to me by the Company upon my request) will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

STREET | CITY | STATE | Zip + 4