



# Student Insurance Claim Form

Upon completion, send this form to:

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

<b>School Name:</b> _____			
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 as 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