SOUTHEASTERN UNIVERSITY
United HealthCare Insurance Company
Policy Number: 2011-592-8

INSURANCE CLAIM FORM

Submit claims to: UnitedHealthcare **Student**Resources**, PO Box 809025, Dallas, TX 75380-9025**

CLAIM FORMS ARE REQUIRED FOR INTERCOLLEGIATE SPORTS INJURIES ONLY

Student/Patient Information **Please print all information**

Name ______________________ Date of Birth ___/___/___ SS# ______________________

Current Address ______________________

Home Address ______________________

Claim Information

Date of accident/sickness ___/___/___ Date of first treatment ___/___/___

Name of sickness/injury ______________________

If accident, how did it occur? ______________________

______________________ Work-related? ______________________

* If sports injury, which sport? ______________________
* Have you previously been troubled with this condition? ______________________ Date ___/___/___
* Were you referred by the Student Health Service? (N/A for summer) ______________________ Date ___/___/___
* Names of other physicians consulted ______________________

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Other Insurance Information (**MUST BE COMPLETED)**

Is the person for whom claim is being made insured under any other plan described below? . . . . Yes ___ No ___

Your mother's or father's insurance? . . . . Yes ___ No ___

Group insurance or any program of benefits or services for individuals as a group? . . . . Yes ___ No ___

Blue Cross Blue Shield or a Health Maintenance Organization (HMO)? . . . . Yes ___ No ___

Any government program of benefits or services? . . . . Yes ___ No ___

Any motor vehicle insurance coverage? . . . . Yes ___ No ___

Any plan of benefits or services provided on an individual basis? . . . . Yes ___ No ___

If the answer to any of the above is "yes" complete the following:

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Name of Policyholder Policy No. Name and address of Company providing benefits or services

Be sure to send copies of all itemized bills to other Company and send us their explanation of benefits (E.O.B) paid on your behalf.

Authorization to Obtain Information

I authorize any physician, medical professional, hospital, clinic, medical care institution or medically related facility, insurance or reinsuring company, medical or hospital service or prepaid health plan, employer or group policyholder, contractholder, or benefit plan administrator to provide the Company and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on the Company's behalf, with information concerning medical care advice, diagnosis, treatment, prognosis, or supplies provided to the Patient, including information relating to mental illness, and any employment-related information regarding the Patient. Where applicable this is also to authorize my University to convey information to the Company regarding my eligibility as a student. I understand that this authorization shall be valid for the term of the Policy(ies). I agree that a photostatic copy of this authorization is as valid as the original.

I certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge and belief, true, correct, and complete. I will reimburse the Insurance Company for any overpayment made to me or in my behalf due to error on this form.

Student's Signature:______________________Date:______________________

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.
NOTIFICATION OF INJURY OR SICKNESS MUST BE PROVIDED WITHIN 30 DAYS AFTER THE DATE OF ACCIDENT OR COMMENCEMENT OF SICKNESS. BILLS MUST BE SUBMITTED WITHIN 90 DAYS OF THE DATE OF TREATMENT

I authorize payment directly to my medical provider(s) for charges incurred for this claim. If I have already made payment, I am enclosing paid receipts in which case I request reimbursement directly to me. I understand that I am financially responsible for all charges not covered by this authorization.

Student's Signature:______________________Date:______________________

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