

COLLEGE CLAIM FORM

Return Address:
GM-SOUTHWEST
P.O. Box 703308
Dallas, Texas 75370-3308

CLAIM INSTRUCTIONS

- **THE CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT OR SICKNESS.**
- All payments will be made to the providers of service (Hospital, Physician and others), unless accompanied by a paid receipt.
 - Mail all ITEMIZED bills showing diagnosis, dates of treatment and charges to GM-Southwest.
 - Benefits will be paid according to the Schedule of Benefits.
- An Explanation of Benefits is required from the primary carrier for each claim, where applicable.

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

Name of School, City and State _____	Grade _____	# of Credit Hours _____	Social Security No. _____
--------------------------------------	-------------	-------------------------	---------------------------

Student's Name _____ SEX _____ BIRTHDATE _____
Last Name First Name

If claim for dependent, give name and relationship _____ SEX _____ BIRTHDATE _____

Present Address _____
No. and Street City or Town State Zip

Home Address _____
No. and Street City or Town State Zip

Date of accident or sickness. If pregnancy, last menstrual period _____	Date of First Treatment _____
---	-------------------------------

Nature of Sickness or Injury _____

If injury, describe fully how and where accident occurred _____

IF INJURED IN PLAY OR PRACTICE OF SPORT, INDICATE WHAT SPORT	CHECK ONE: <input type="checkbox"/> INTRAMURAL <input type="checkbox"/> INTER COLLEGIATE <input type="checkbox"/> CLUB
---	---

Have you ever had the same or similar symptoms Yes No If so, when? _____ 19

Were you treated by the Student Health Service? Yes No Date: _____

Name and address of Physician _____

Give names of all other physicians consulted _____

Hospitalized From: _____ 19 To: _____ 19

Name and Address of Hospital _____

Is the person for whom this claim has been filed covered under any other type of health insurance, group or individual, including coverage through an employer, or dependent coverage by a spouse or parent? YES _____ NO _____

If "yes", please provide the following information:

Name of other policyholder _____ Relationship to claimant? _____

Other policyholder's Social Security # _____ Name of other Insurance Company _____

Other Policy # _____ Is the other policy Group or Individual? _____

If other policy is Group, please name the organization providing coverage (employer, etc.): _____

If you previously had other health insurance coverage, which might qualify as Creditable Coverage, please provide a copy of the "Certificate of Creditable Coverage" attached to this claim form.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

AFFIDAVIT	
I HEREBY VERIFY that the information provided on this form is true and complete.	
_____ Signature of Patient (parent/guardian if minor)	_____ Date Signed

IF YOU HAVE AN ITEMIZED STATEMENT FROM THE PROVIDER OF SERVICES, ATTACH THE STATEMENT(S) TO THIS FORM AND DISREGARD THIS SECTION.

TO BE COMPLETED BY ATTENDING PHYSICIAN

Please Print or Type

1. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	2. DATE FIRST CONSULTED YOU FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Was there any congenital, pre-disposing or pre-existing condition relevant to this injury or illness? If yes, please explain.		4. FOR SERVICE RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES				
5. NAME OF REFERRING PHYSICIAN		IF HOSPITALIZED-GIVE NAME AND ADDRESS OF FACILITY				
6. ARE THESE CHARGES BEING SUBMITTED FOR CONSIDERATION BY ANOTHER INSURANCE CARRIER?		I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)				
7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE 1. 2. 3. 4.						
8.	A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:) (Explain Unusual Services or Circumstances)	D DIAGNOSIS CODE	FEE	ADMINISTRATIVE USE ONLY
9. SIGNATURE OF PHYSICIAN OR SUPPLIER			*PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE 11. PROVIDER SOCIAL SECURITY NO.	10. TOTAL CHARGE	12. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	
13. YOUR PATIENT'S ACCOUNT NO. 15. YOUR PATIENT'S NAME 16. YOUR PATIENT'S AGE			12. PROVIDER TAX I.D. NO.			

MUST BE ANSWERED ON ALL DENTAL CLAIMS: Condition of Teeth prior to accident (indicate whole, sound, natural, filled, capped, or artificial)						
1. DENTIST NAME		6. Is Treatment Result of Occupational Illness or Injury?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATE
2. MAILING ADDRESS		7. Is Treatment Result of Auto Accident? Other Accident?				
3. CITY, STATE, ZIP		8. Are Any Services Covered By Another Plan?				
4. DENTIST SOC. SEC. OR T.I.N.*		DENTIST LICENSE NO.	DENTIST PHONE NO.	9. If Prosthesis, Is This Initial Placement?		(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR REPLACEMENT
5. HAS TREATMENT BEEN COMPLETED?	YES	NO	IF NOT, WHAT MUST BE DONE AND WHEN?	10. Is Treatment for Orthodontics?		If Services Already Commenced, Enter DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

	TOOTH # OR LETTER	SUR-FACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER ADA CODES	FEE	ADMINISTRATIVE USE ONLY	
I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.						TOTAL FEE	\$	
SIGNED (DENTIST) _____			DATE _____		Your Patient's Account No. - _____			
					Your Patient's Age - _____			