



## STUDENT HEALTH INSURANCE CLAIM FORM

PART 1 of 2

This claim form is to be used only if your provider did not file claims directly to GBG on your behalf. Return this form along with fully itemized bills and diagnosis to the address below. **Claims must be received by GBG Administrative Services within ninety (90) days after first day of treatment.**

<b>Section I: Member Information</b>			
Name (Last, First, MI):	School Name:	Member ID:	
Address:	City:	State:	Zip:
Phone Number:	Alternate Number:	E-Mail Address:	
<b>Section II: Patient Information</b>			
Patient Name:	Sex: Male <input type="checkbox"/>	Date of Birth:	
E-Mail Address (if different than above)	Female <input type="checkbox"/>	Relationship to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/>	
Date of Illness:	Describe symptoms:		
Is this claim for Maternity treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>		Date of last menstrual period:	Indicate delivery date:
Name of Treating OB/GYN:		Date you first consulted a physician:	
Name and Address of Physician/Facility First Consulted:			
Have you ever sought treatment for this illness in the past: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please describe past treatment and dates of treatment:			
If treated in your Home Country for this condition/symptoms or a similar condition, indicate the treatment recommended/ medication prescribed and date first treated:			
Please provide your Home Country details:			
<b>If Condition is related to an Injury - Please complete the Section Below</b>			
Date of Injury:	Describe where and how injury occurred:		
<b>Is the Injury related to:</b> <input type="checkbox"/> Auto Accident (attach copy of Police report) <input type="checkbox"/> Work related injury <input type="checkbox"/> School sponsored trip/ Activity <input type="checkbox"/> During practice or Play of an Intercollegiate Sport (attach copy of school injury report) <input type="checkbox"/> <input type="checkbox"/> Sport/ Activity outside of School <input type="checkbox"/> Other (specify):			
If a motor vehicle injury, list names of all drivers and Companies Insuring all drivers and or vehicle's:			
Have you ever sought treatment for this injury in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe past treatment or recommended treatment and dates:			



CLAIM FORM PART 2 of 2

Section III: Other Insurance Information	
Does the patient have other Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Insurance Company's Name and address:
Is this a Group health Insurance Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holders Name for other coverage:
	Other Insurance carrier's Policy Number and effective date:
Please complete the information below if the patient is covered by Medicare	
Medicare ID Number:	Is the patient eligible for: Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part A & B <input type="checkbox"/> or Part D <input type="checkbox"/>
Section IV: Payment Information	
<p>Member will only be reimbursed if acceptable proof of payment is submitted with claim.            For member:            Acceptable proof of payment includes receipts from the Provider(s) and <b>itemized</b> billings noted for hospital or physicians.            For Hospital Charges:            All hospital submissions must be itemized on a UB-92 form with proof of payment (box 54) completed.            For Physician charges:            All physician submissions must be itemized on a HFCA/CMS-1500 form with proof of payment (box 29) completed.</p>	
Please make payment to: <input type="checkbox"/> Member <input type="checkbox"/> Provider (assignment of benefits must be completed on the itemized bill in box 12 and 13 of the HFCA/CMS-1500 or a "Y" in box 53 on the UB-92)	
Send Check and Explanation of Benefits to: <input type="checkbox"/> Member address on Section I <input type="checkbox"/> Other Mailing Address: _____ <input type="checkbox"/> Send by Electronic Transfer (US Bank Accounts only): Name on Account (must be subscribers bank account): _____ Name and Address of Bank: _____ Bank Routing Number: _____ Account #: _____	
Section V: Authorization and Signature Required	
I authorize any health care provider, medically related facility, health care plan, insurance company, and the Medical Information Bureau and their representatives to give GBG Claims/Trawick Insurance Company or their agent's any and all information, including complete medical history records and mental health and substance abuse records, for consideration of this claim and all future claims. A photocopy of this form shall be just as valid as the original. I hereby certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for the charges incurred by the above named member.	
Member Signature:	Date:
Member/Guardian's Signature if patient is a Minor:	Date:

**FRAUD WARNING:** Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

**Please submit your current Passport and VISA along with this claim form.**