

TO BE COMPLETED BY STUDENT

1. School Name: Florida International University Policy # 131068

2. Student Name: _____ ID Number: _____

3. Student Local Address _____
Number Street City State Zip

4. Student Home Address _____
Number Street City State Zip

5. Date of Birth ____/____/____ Local Phone (____) _____ Home Phone (____) _____

6. Gender: Male Female

7. Is this a claim for a dependent? Yes No If yes, give name _____
 Relationship _____ Date of Birth ____/____/____

8. Name of physician _____ Date of Initial Service ____/____/____

9. Description of illness or injury _____

10. Has the patient been treated for the above condition(s) in the last 6 months? Yes No
 If yes, give condition(s) treated for and date (s) of treatment _____

11. Is this claim the result of an accident? Yes No If yes, give date of accident ____/____/____
 Where did the accident occur? _____
 How did the accident happen? _____

12. Is this claim the result of a work-related injury? Yes No

13. Is this claim the result of intercollegiate sports? Yes No

14. Is patient covered for benefits (other than this policy) by any of the following:
 Yes No Group Health Benefits of any kind through an employer, spouse's employer, or parent's employer
 Yes No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency
 If any of the above apply, please complete the following:
 Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____
Name Relationship
 Insurance Co. or Benefit Plan _____ Sponsor or employer _____
 Insurance Co. Address _____ Sponsor Address _____
 Telephone (____) _____ Plan/Group Number _____ Sponsor Telephone (____) _____
 If Blue Cross, show Group and Certificate No. from Blue Cross ID Card _____
Group # Certificate

15. Is patient covered under MEDICARE (please mark all that apply): Part A Part B Not Covered
 If covered, give effective dates: Part A: Mo. ____/Day ____/Year ____ Part B: Mo. ____/Day ____/Year ____

16. Is patient related to the provider of services? Yes No If yes, state the relationship _____

17. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested with respect to this claim.

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

Date ____/____/____ Signature of Student _____
 Date ____/____/____ Signature of Patient _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to any provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Date ____/____/____ Signature _____

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM:

1. An initial claim is being submitted for a different family member.
2. A new claim is being submitted for a completely different illness or injury.

HOW TO FILE A CLAIM:

1. Complete the applicable items on the reverse side.
2. Promptly mail this form with any itemized bills to UniCare.
3. If you receive additional bills on this claim after you have mailed this form, it is not necessary to complete another form.
4. Identify bills by adding the following information:
 - College's Name and Policy Number
 - Student's Name and Social Security Number
 - Patient's Name

MAIL ALL CLAIMS TO:

**UniCare
P.O. Box 4458
Chicago, IL 60680-4458**

Please remember to always make a copy of your claim forms before mailing to our office.