Dartmouth Student Group Health Plan
Medical Claim/Referral Form

DARTMOUTH

Klais & Company, Inc.
1867 West Market Street
Akron, Ohio 44313-6977
Telephone: 800-331-1096

INSTRUCTIONS

1. Complete this form once for each illness, injury, condition or referral.
2. Your complete response is required. Please fill in N/A where items do not apply.
3. Attach all bills to form and send to Klais & Company, Inc.
4. You will receive a written Explanation of Benefits (EOB) when the claim is processed.

PART I. STUDENT AND PATIENT

Student Name________________________________ Soc. Sec. No. ____________________

Mailing Address ____

Student's Date of Birth (DOB) ____________________ Telephone No. ____________________ Group No. SH404

Nature of Illness/Injury/Condition: ______________________________Date FirstTreated____________________

Patients Name (if not student) ____________________ Relationship to student ____________ Patient DOB ________

Spouse Name (if applicable): ____________________ Spouse Soc. Sec. No. ______________ Spouse DOB ________

PART II. COMPLETE IF CLAIM IS FOR ACCIDENT OR INJURY

Did Accident/Injury occur at work? Yes No If yes, has a claim been filed with Worker's Compensation? Yes No

Did Accident/Injury occur during a Dartmouth Varsity/Club Sport game/practice? Yes No

Name of Varsity/Club Sport ____________________Name of Athletic Trainer ____________________

PART III. COMPLETE THIS SECTION IF CLAIM IS FOR SERVICES RECEIVED IN HANOVER, NH AREA.

Were these services ordered by or referred by the Health Service? Yes No

Name of Health Service practitioner who referred you ____

If you were not referred, explain why ____

PART IV. COORDINATION OF BENEFITS.

Are you, the Patient or your Spouse covered under any other group plan, Health Maintenance Organization ,Government Plan, or Insurance Policy which will pay for the expenses of this Claim? Yes No

If Yes. Give the name, address and policy number of Plan Providing Benefits.

Name: ____Policy Number: ____________________

Address: ____

PART V. RELEASE AND AUTHORIZATION. PATIENT OR PARENT MUST SIGN BELOW.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S)

I hereby authorize payment of benefits otherwise payable to me to be paid directly to any provider of service, provided payments do not exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.

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Student Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

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Patient or Parent Signature (for minor) Date