如何填写索赔表

学生应填写所有信息

Relation

Relation Insurance Administrators
P.O. Box 6040
Agoura Hills, CA 91376-6040

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION	POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME	INSURED'S FIRST NAME	MI
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP		
INSURED'S DATE OF BIRTH (MM/DD/YY) / / ☐ FEMALE ☐ MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME	CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP		
CLAIMANT'S DATE OF BIRTH (MM/DD/YY) / / ☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? ☐ Sickness ☐ Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:
   Date of Injury: ____________________
   b) Did injury occur at work? ☐ No ☐ Yes If yes, name of employer: ____________________
   c) Did injury occur during practice or play of school-sponsored sports? ☐ No ☐ Yes If yes, please complete information about the sport below.
   Name of Sport: ____________________ ☐ Intercollegiate ☐ Intramural/Club
   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: ____________________

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ No ☐ Yes ☐ N/A (skip to Section 3)
   If yes, signature and title of health center official: ____________________
3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ No ☐ Yes
   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: ____________________
   Member No.: ____________ Group No.: ____________ Insurance Co. Phone No.: ____________
   Primary Insured's Name (Parent/Spouse/Self): ____________________

SECTION 4 – ASSIGNMENT OF BENEFITS

5. Indicate below to whom payment is to be made:
   ☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.
   ☐ Expenses have been paid by the patient/insured. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Administrators, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature____________________ Date ____________

If student is under age 18, must be signed by a parent or guardian.

IMPORTANT: This form must be completed and returned to Relation Insurance Administrators within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements on page 2).

YOU CAN SUBMIT THIS COMPLETED FORM BY MAIL OR FAX USING THE INFORMATION BELOW. CLAIMS ARE NOT ACCEPTED VIA EMAIL.

Claims Mail: Relation Insurance Administrators, P.O. Box 6040, Agoura Hills, CA 91376-6040
Claims Fax: (818) 735-3567
Customer Service: (800) 468-4343
Customer Service E-Mail: riainfo@relationinsurance.com

1. 填入学生信息
此部分要求填写基本身份信息，如姓名、地址和学生 ID。国际学生应填写当前美国住址，而非海外永久家庭住址。

1b. 如由受保的被抚养人填写这份索赔表，请在“索赔人”部分填写被抚养人信息。

2. 受伤或患病信息
此部分要求填写患病或受伤的所有细节。如上报受伤情况，索赔管理员应了解受伤发生的具体时间，如工作、运动或驾驶车辆期间。

3. 转介信息
如要求某一健康中心转介，或由于有某一健康中心转介，可豁免免赔额，则必须填写此部分并附上转介资料。

4. 其他承保信息
如学生获得其他计划的承保，则学校计划将作为第二付款人，在这种情况下，对于其他计划未支付的应付金额，学生必须先向其他相关保险公司提交一份索赔表，然后向第二关系人提交索赔表。

5. 利益分配
此部分告知索赔管理员应进行付款的相关人员。

6. 签名和日期
此部分用于披露个人信息，以便医疗提供者与索赔管理员可分享相关医疗信息。

7. 重要信息
此表必须在自治疗日期开始的 90 天之内填妥并交回公司，并随附至交回之日所产生的所有费用账单。请附上详细账单。

8. 随附学生健康中心转介
如要求某一健康中心转介，或由于有某一健康中心转介，可豁免免赔额，请确保附上健康中心转介资料。

9. 随附详细账单
确保将所有详细账单以及处方药收据（如适用）随同索赔表一起寄出。建议在您所附的所有账单上写下姓名和学生编号。

10. 通过邮政或传真发出已填妥的表格。