HOW TO COMPLETE A CLAIM FORM

ALL INFORMATION SHOULD BE COMPLETED BY THE STUDENT

MEDICAL EXPENSE
Claim Form and Instructions

GeoBlue
GeoBlue is the trade name of Worldwide Insurance Services, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

1. PATIENT INFORMATION

Member ID	*Please enter Member ID as shown on card*		
Patient's Name *(Given Name, Family Name)*	Patient's date of birth *(MM/DD/YYYY)*	Patient's Gender	
		○ Male ○ Female	
Name of Insured Member *(Given Name, Family Name)*	Insured's date of birth *(MM/DD/YYYY)*	Patient's Relationship to Insured	
		○ Self ○ Spouse ○ Child	
Name of Plan Program Sponsor	Insured's current mailing address		
Member Email	Member Phone Number		

2. OTHER HEALTH INSURANCE

Is the patient covered under other health insurance?	○ YES ○ NO	***If YES**, please complete this section*	
Name and address of other insurance company		Name of the Policy Holder	
Policy Holder's Date of Birth *(MM/DD/YYYY)*	Policy or identification number of other coverage	Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/DD/YYYY)*

3. DIAGNOSIS – *describe illness, injury or symptoms requiring treatment*

IF IN AN ACCIDENT

Date of Accident *(MM/DD/YYYY)*		Place of Accident			
Date of Doctor/Hospital Visit *(MM/DD/YYYY)*		Was the injury a result of participation in an Intercollegiate Sport?	○ YES ○ NO	Was this an Auto Accident?	○ YES ○ NO
Description/Details of Injury *(attach additional notes if necessary)*					

IF SICKNESS/ILLNESS

Onset Date of Symptoms *(MM/DD/YYY)*		Date of Doctor/Hospital Visit *(MM/DD/YYYY)*	
Have you had this Sickness/Illness before?	○ YES ○ NO	If YES, when was the last occurrence and/or doctor/hospital visit?	
Description/Details of Illness *(attach additional notes if necessary)*			

4. CHARGES – *use a separate line to list each type of service or provider and attach itemized bills for all services*

Name, City & Country of provider making charge	Diagnosis	Description of service *(Office Visit, X-ray, Prescription, etc.)*	Dates of Service *(MM/DD/YYYY)*	Charges *(Please indicate currency)*

5. CLAIM PAYMENT REIMBURSEMENT

Have these doctor/hospital bills been paid by you?	○ YES ○ NO	If YES, payment will be made to Primary Insured via Check *(payable in US$ and mailed to the address indicated above)*
If NO, do you authorize payment to the provider of service for medical services claimed?	○ YES ○ NO	*If payment is to be paid to an international provider, please ensure bank information is on the provider invoice. See Filing Instructions for non-international provider payments*

6. SIGNATURE

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to GeoBlue and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Please see the back of this form for important information.

Signature of Insured member or patient		Date	

GeoBlue Student Claim Rev. 04/16

1. Enter Student Information
This section asks for basic identifying information, such as name, address, and student ID. International students should use their current U.S. address, not their permanent home address abroad. Under "Name of Plan Program Sponsor," write "GeoBlue."

2. Other Health Insurance
This section asks for information on whether a student has other insurance. If they are not covered by another insurance plan, fill in the "No" bubble.

3. Diagnosis
This section asks for all the details of the sickness or injury. If reporting an injury, it's important for the claim administrator to understand if injury happened while on the job, playing sports, or riding in an automobile.

4. Charges
This section asks for an itemized list of each service or provider. Write the name of the provider, their location, the diagnosis, the type of service, the dates of service, and all charges incurred and attach your receipts.

5. Claim Payment Reimbursement
This section instructs the claims administrator to whom payments should be made.

6. Sign and Date
This section is used as a release of personal information so that medical providers and the claims administrator can share pertinent medical information.

7. IMPORTANT
This form must be completed and returned to the company within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills.

8. ATTACH STUDENT HEALTH CENTER REFERRAL
If a health center referral is required, or if the deductible is waived with a health center referral, make sure to include health center referral.

9. ATTACH ITEMIZED BILLS
Make sure to send all itemized bills, as well as prescription drug receipts, if applicable, with claim form. It's a good idea to write your name and student number on all bills you attach.

10. MAIL THE COMPLETED FORM TO: GeoBlue, P.O. Box 21974, Eagan, MN 55121