

HOW TO COMPLETE A CLAIM FORM

ALL INFORMATION SHOULD BE COMPLETED BY THE STUDENT



Relation Insurance Services
P.O. Box 25936
Overland Park, KS 66225

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)	<input type="checkbox"/> FEMALE <input type="checkbox"/> 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)	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	CLAIMANT'S PHONE NUMBER	

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.

1b. If an insured dependent is filing the claim, fill out the "claimant" section with dependent's information.

2. Injury or Sickness Information

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.

3. Referral Information

If a health center referral is required, or if the deductible is waived with a health center referral, this section must be completed and the referral must be attached.

4. Other Insurance Coverage

If the student has coverage under another plan, the school plan will pay secondary, in which case the student must submit a claim to the other insurance first, then to Relation second for covered amounts not paid by the other plan.

5. Assignment of Benefits

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.

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 Services, 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 Services 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 Services, P.O. Box 25936, Overland Park, KS 66225
Claims Fax: (913) 327-7520
Customer Service: (877) 246-6997
Customer Service E-mail: claims@relationinsurance.com

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. SEND THE COMPLETED FORM EITHER BY MAIL OR FAX.