Administrative Concepts, Inc.
PO Box 4000
Collegeville, Pennsylvania 19426

OTHER INSURANCE COVERAGE FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

In order to process your medical claims it is required that you complete, sign, date, and return this questionnaire to confirm your insurance coverage status. If you are only insured through your student health plan and do NOT have any other coverage, please check "No" below, then sign, date, and return this form. If you do have other health insurance coverage through an employer, parent, spouse, etc., please complete other insurance information, then sign and date this form. You are only required to complete this form once per academic year.

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 #)			APT./UNIT #
CITY		STATE	ZIP
INSURED'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

Do you, your spouse, your domestic partner, or your parents have other medical insurance, either group or individual, under which you are covered?

☐ Yes ☐ No If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse

Name of Insurance Carrier: _____

Address of Insurance Company: _____

Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

If you are covered under more than one policy, please use an additional sheet.

I certify the above information to be true and correct.

Signature: _____ Date: _____

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

Claims Mail:	Administrative Concepts, Inc., PO Box 4000, Collegeville, Pennsylvania 19426
Fax:	(610) 293-9299
Customer Service:	(800) 476-4802
E-Mail:	claims@visit-aci.com

Clear Form