How to Complete a Claim Form

ALL INFORMATION SHOULD BE COMPLETED BY THE STUDENT.

Ascension™

Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
(800) 468-4343

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			
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			
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 ❑
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 Personal Insurance Administrators, Inc., an Ascension Company, 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 Personal 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).

MAIL COMPLETED FORM TO: Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040

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 PIA 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.

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: Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040