PLAN YEAR 2007-2008

HEALTH INSURANCE CLAIM FORM

Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

If you have questions call: **AmeriBen (800) 953-1801**

Type or Print

PATIENT AND INSURED INFORMATION 1. - Patient's Name (First, Middle Initial, Last)	2 .– Patient's Date of Birth	3. Insured's Name (First, Middle Initial, Last)
4. – Patient's Address (Street, City, State, Zip Code	5. - Patient's Sex ☐ Male ☐ Female	6. – Insured's I.D. No. or Medicare No. (Include any Letters) (Social Security No.)
	7. – Patient's relationship to Insured SELF SPOUSE CHILD OTHER ☐ ☐ ☐ ☐	8. – Insured's Group No. **0190409** **Western Washington University**
9. – Other health insurance coverage – enter name of policy-holder, plan name and address and policy or medical assistance number.	10.- Was Condition Related to: (A) Patient's Employment Yes ☐ No ☐ (B) An Auto Accident Yes ☐ No ☐	11. – Insured's Address (Street, City, State, Zip Code)

12. – Nature of injury:

13. – Patient's or authorized person's signature I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. **X.**	14. – Date	15. – Signature (Insured or Authorized Person) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER OF SERVICES. **X.**

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, school, or third party administrator, having information as to diagnosis, treatment and/or prognosis of any of my mental conditions (and any of my non-medical information necessary to the processing of claims), to give the blanket policyholder, Ameriben/IEC Group, INC., GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, or their legal representatives, any and all such information. I specifically consent to the release of any of the above information which may be protected under the Family Educational and Privacy Rights Act including without limitations records of enrollment, attendance or payment of tuition related to my attendance at any Educational Institution to the blanket policyholder, Ameriben/IEC Group, GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, or their legal representatives.

I UNDERSTAND the information obtained with this Authorization will be used to determine my eligibility for coverage and/or benefits under a student blanket insurance plan. Any such information will not be released by Ameriben/IEC Group or GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, except to the blanket policyholder, third party administrator, reinsuring companies, or other persons or organizations performing services in connection with the plan, or as may be otherwise lawfully required.

I AGREE that a copy of this Authorization shall be as valid as the original; this Authorization shall be valid for twelve months from the date shown below, or for the duration of this claim, if longer; and I am aware that I may request a copy of this Authorization.

WESTERN WASHINGTON UNIVERSITY
GROUP NUMBER: # 0190409
PROCEDURE FOR FIILING A CLAIM

I. Complete the Claim Form above.

1. **Make sure you complete all questions.**
2. **It is important to know when, how and where your accident, illness or disability began especially if it is job related.**
3. **Questions regarding other coverage you or your dependents are eligible for must be answered.**
4. **If payment is to be made to the provider you should sign Section 15.**
5. **Patient or parent (if patient is minor) must always sign the "I authorize the release of any medical information necessary to process this claim." (Section 13).**

II. If you have other coverage, (include Medicare or CHAMPUS), make sure you attach all payment statements or declination letters.

III. Attach all medical claims and/or prescription receipts relating to claim.

1. **Make sure all bills identify patient.**
2. **All bills should show date of treatment, type of service, and amount of charges.**
3. **Mail claims to GWL at:**

Great-West Healthcare
1000 Great-West Drive
Kennett, MO 63857-3749
NEIC# 80705

Questions about Claims call:
AmeriBen
(800) 953-1801