

Mail the completed claim form packet to:

AmeriBen Solutions  
P.O. Box 7186, Boise, ID 83707  
800-953-1801

ACE American Insurance Company

**CLAIM INFORMATION FORM**

Name of University \_\_\_\_\_ Insured Student's SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Insured's Student I.D. # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Patient's Sex: Male  Female   
Relationship to Insured: Self  Spouse  Child  Insured Student's Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Home Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Patient's Date Of Birth: \_\_\_\_\_

**Complete This Section For Accident Or Injury:**

Date of Accident: \_\_\_\_\_ Place of Accident: Home  Work  Other (Describe): \_\_\_\_\_  
Describe Accident (What Happened): \_\_\_\_\_  
Sports Injury: Yes  No  If Yes Indicate Sports Activity: Intercollegiate  Intramural  Club  Other   
Describe Extent and Nature of Injury: \_\_\_\_\_

**Complete This Section For All Other Medical Conditions:**

Describe Illness or Medical Problem: \_\_\_\_\_  
When Did Present Illness or Medical Problem Begin? Date: \_\_\_\_\_  
Have You Had This Illness or Medical Problem Before? No  Yes  If Yes, When? Date: \_\_\_\_\_  
Present Attending Doctor or Clinic: \_\_\_\_\_ Address: \_\_\_\_\_  
Any Other Attending Doctor or Clinic: \_\_\_\_\_ Address: \_\_\_\_\_  
Family Doctor or Dentist or Clinic: \_\_\_\_\_ Address: \_\_\_\_\_  
Name & Address of Hospital if Confined: \_\_\_\_\_ Dates Of Confinement: From: \_\_\_\_\_ To: \_\_\_\_\_

Are You, Your Spouse, or Child Insured as a Subscriber or a Dependent Under Any Other Group Plan, HMO, or Insurance Policy For Which You May Be Eligible For Benefits For This Condition? Yes  No  Is this plan an: HMO  PPO  Other: \_\_\_\_\_  
If Yes, Complete The Following Information: Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber Ss#: \_\_\_\_\_  
Subscriber's Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Have You Been Insured With Another Health Insurance Plan Any Time During The Past 12-Month Period: Yes  No   
If Yes, Complete The Following Information: Effective Date Of Coverage: \_\_\_\_\_ Date Continuous Coverage Terminated: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Address: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and believe true, correct and complete. Authorization must be given to the insurance company in order to facilitate a prompt equitable claims statement. I authorize payment directly to my medical provider(s) for charges incurred for all claims. If I have already made payment, I am enclosing paid receipts in which case I request reimbursement directly to me. I understand that I am financially responsible for all charges not covered by this authorization. I also authorize Ameriben Solutions or its representatives to pay all bills in connection with this claim directly to the doctor, hospital, or any other persons rendering service, and such payment shall release Ameriben Solutions from liability as to amounts so paid. I hereby authorize any physician, hospital, company, employer or organization to release any information regarding the medical history, treatment, or benefits payable for this claim to Ameriben Solutions. A photocopy of this authorization shall be as valid as original.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge believe the information is complete and correct as given herein.

For your protection, California law requires the following to appear on this form: "any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Date: \_\_\_\_\_ Student's Printed Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

**SUBMIT THIS CLAIM FORM WITHIN 90 DAYS OF SERVICE**

**Student Health Insurance Plan**

**INSTRUCTIONS FOR FILING A CLAIM**

**The Claim Packet that you submit to the insurance company must include the following:**

- 1. Your Completed claim form (First Page of this form).**
  - a. This form is to be completed by the student claiming benefit for self or dependent.
  - b. All questions must be answered.
  - c. All signature requests must be signed.
  
- 2. Referral Requirements.**
  - a. Please refer to your Student Health Center or your insurance brochure for any Student Health Center Referral Requirements.
  - b. If a referral is required, please go to your Student Health Center to complete the referral form.
  
- 3. Itemized Billing Statements.**
  - a. Itemized statements must be presented on official letterhead of provider and must contain the following:
    - i. Patients name,
    - ii. Service date,
    - iii. Service rendered and charge,
    - iv. Diagnosis for each service.
  
- 4. Paid Receipts.**
  - a. If you already paid for the service, include your receipt(s).

**MAIL THE COMPLETED CLAIM FORM PACKET TO:  
AMERIBEN SOLUTIONS  
P.O. Box 7186  
Boise, ID 83707  
1-800-953-1801**

**FOR CLAIM STATUS INFORMATION  
OR GENERAL QUESTIONS CONTACT  
AMERIBEN SOLUTIONS  
1-800-953-1801**

**We recommend that you keep a photocopy of the claim packet for your records.**