COLLEGE CLAIM FORM

Return Address:
GM-SOUTHWEST, Inc.
P.O. Box 6000
Frisco, TX 75034

CLAIM INSTRUCTIONS

- **THE CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT OR SICKNESS.**
- All payments will be made to the providers of service (Hospital, Physician and others), unless accompanied by a paid receipt.
- Mail all ITEMIZED bills showing diagnosis, dates of treatment and charges to GM-Southwest, Inc.
- Benefits will be paid according to the Schedule of Benefits.
- An Explanation of Benefits is required from the primary carrier for each claim, where applicable.

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

Name of School, City and State	Grade	# of Credit Hours	Student ID Number

Student's Name _____ SEX _____ BIRTHDATE _____
Last Name First Name

If claim for dependent, give name and relationship _____ SEX _____ BIRTHDATE _____

Present Address _____
No. and Street City or Town State Zip

Home Address _____
No. and Street City or Town State Zip

Date of accident or sickness. If pregnancy, last menstrual period		Date of First Treatment

Nature of Sickness or Injury	
If injury, describe fully how and where accident occurred	
IF INJURED IN PLAY OR PRACTICE OF SPORT, INDICATE WHAT SPORT	**CHECK ONE:** ☐ **INTRAMURAL** ☐ **INTER COLLEGIATE** ☐ **CLUB**
Have you ever had the same or similar symptoms	☐ Yes ☐ No If so, when? 20
Were you treated by the Student Health Service?	☐ Yes ☐ No Date:
Name and address of Physician	
Give names of all other physicians consulted	
Hospitalized	From: 20 To: 20
Name and Address of Hospital	

Is the person for whom this claim has been filed covered under any other type of health insurance, group or individual, including coverage through an employer, or dependent coverage by a spouse or parent? YES _____ NO _____

If "yes", please provide the following information:

Name of other policyholder _____ Relationship to claimant? _____

Other policyholder's ID # _____ Name of other Insurance Company _____

Other Policy # _____ Is the other policy Group or Individual? _____

If other policy is Group, please name the organization providing coverage (employer, etc.): _____

If you previously had other health insurance coverage, which might qualify as Creditable Coverage, please provide a copy of the "Certificate of Creditable Coverage" attached to this claim form.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

AFFIDAVIT

I HEREBY VERIFY that the information provided on this form is true and complete.

_____ _____
Signature of Patient (parent/guardian if minor) Date Signed

IF YOU HAVE AN ITEMIZED STATEMENT FROM THE PROVIDER OF SERVICES, ATTACH THE STATEMENT(S) TO THIS FORM AND *DISREGARD* THIS SECTION.

TO BE COMPLETED BY ATTENDING PHYSICIAN

Please Print or Type

1. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		2. DATE FIRST CONSULTED YOU FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
Was there any congenital, pre-disposing or pre-existing condition relevant to this injury or illness? If yes, please explain.			4. FOR SERVICE RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
5. NAME OF REFERRING PHYSICIAN			IF HOSPITALIZED-GIVE NAME AND ADDRESS OF FACILITY
6. ARE THESE CHARGES BEING SUBMITTED FOR CONSIDERATION BY ANOTHER INSURANCE CARRIER?			I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)

7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

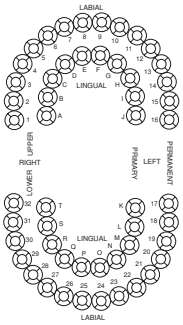
8. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(Explain Unusual Services or Circumstances)	D DIAGNOSIS CODE	FEE	ADMINISTRATIVE USE ONLY

9. SIGNATURE OF PHYSICIAN OR SUPPLIER	*PLACE OF SERVICE CODES 1–(H) – INPATIENT HOSPITAL 2–(OH) – OUTPATIENT HOSPITAL 3–(O) – DOCTOR'S OFFICE	10. TOTAL CHARGE	
	11. PROVIDER ID NO.	12. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	
13. YOUR PATIENT'S ACCOUNT NO. 15. YOUR PATIENT'S NAME 16. YOUR PATIENT'S AGE	12. PROVIDER TAX I.D. NO.		

DENTIST

MUST BE ANSWERED ON ALL DENTAL CLAIMS: Condition of Teeth prior to accident (indicate whole, sound, natural, filled, capped, or artificial)

1. DENTIST NAME		6. Is Treatment Result of Occupational Illness or Injury?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATE
2. MAILING ADDRESS		7. Is Treatment Result of Auto Accident? Other Accident?			
3. CITY, STATE, ZIP		8. Are Any Services Covered By Another Plan?			
4. DENTIST ID NO. OR T.I.N.*	DENTIST LICENSE NO. / DENTIST PHONE NO.	9. If Prosthesis, Is This Initial Placement?			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR REPLACEMENT
5. HAS TREATMENT BEEN COMPLETED?	YES / NO / IF NOT, WHAT MUST BE DONE AND WHEN?	10. Is Treatment for Orthodontics?			If Services Already Commenced, Enter / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING



INDICATE MISSING TEETH WITH AN 'X'

TOOTH # OR LETTER	SUR-FACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER ADA CODES	FEE	ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE $

Your Patient's Account No.–

Your Patient's Age –

Must be furnished under Authority of Law when Benefits Assigned