Colgate University

Student Health Insurance Claim Form

Submit Claims to:
Student Resources
Student Insurance Division
P.O. Box 809025
Dallas, TX 75380-9025

Student Identification:

Student Name ______________________________ Male ☐ Female ☐

SS#/Student ID# ______________ Date of Birth ______________ Marital Status ______________

Current Address ______________________________

Home Address ______________________________

Prescription Claims:

Complete Student Identification information, sign form at bottom and return to above address with original receipts attached.

Claim Information:

Describe sickness/injury suffered ______________________________

Date sickness began/injury occurred ______________________ Time ______________

How did injury occur?

____

Where did injury occur?

____

Medical History:

Name of first doctor that treated you for this sickness/injury ______________________________

Address ______________________________ Phone ______________

Have you suffered from the same or a similar condition in the past? Yes ☐ No ☐ If yes, when? ______________

Were you treated for the same or similar condition in the past? Yes ☐ No If yes, when? ______________

Please give name and address of treating physician ______________________________

Name and address of Family Doctor ______________________________

Student Health Center Referral:

If your policy contains a Student Health Center Referral Requirement, this section must be completed by Student Health Services.

Stamp here for Referral

Date of Referral ______________________________

Referring practitioner ______________________________

Other Insurance:

Do you have other insurance which covers this condition? Yes ☐ No ☐

Name of policyholder ______________________ Relationship to patient ______________

Name and address of company ______________________ Policy No. ______________

If yes, have these charges been submitted through your other carrier? Yes ☐ No

Authorization to Obtain Information

I authorize any physician, medical professional, hospital, clinic, medical care institution or medically related facility, insurance or reinsuring company, medical or hospital service or prepaid health plan. employer or group policyholder, contract holder, or benefit plan administrator to provide the Company and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on the Company's behalf, with information concerning medical care, advice, diagnosis, treatment, prognosis, or supplies provided to the Patient, including information relating to mental illness, and any employment-related information regarding the Patient. Where applicable this is also to authorize my University to convey information to the Company regarding my eligibility as a student. I understand that this authorization shall be valid for the term of the Policy(ies). I agree that a photostatic copy of this authorization is as valid as the original.

I certify that the foregoing statements, including any accompanying statements are to the best of my knowledge and belief, true, correct and complete. I will reimburse the Insurance Company for any overpayment made to me or in my behalf due to error on this form.

Patient's Signature ______________________________ Date ______________

Authorization for Payment

I authorize payment directly to my medical provider(s) for charges incurred for this claim. 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.

Patient's Signature ______________________________ Date ______________