

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS
STUDENT and DEPENDENT CLAIM FORM

PLAN YEAR 2011-12

HEALTH/DENTAL 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
 (855) 639-8679

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	6. - Insured's Student ID Number (or Dependent SS#)
	7. Patient's relationship to Insured SELF SPOUSE CHILD OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. - Insured's Group No. 0811008 University of Colorado Anschutz Medical Campus
7. - Other health insurance coverage – enter name of policyholder, plan name and address and policy or medical assistance number.	8.- Was Condition Related to: (A) Student's Employment Yes <input type="checkbox"/> No <input type="checkbox"/> (B) An Auto Accident Yes <input type="checkbox"/> No <input type="checkbox"/>	

9. - Nature of injury:

10. Patient's or authorized person's signature I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. X.	11. Date	12. Signature (Insured or Authorized Person) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER OF SERVICES. X.
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UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS
GROUP NUMBER: #0811008
PROCEDURE FOR FILING 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 fit 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 12.**
 - 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 10).**
- II. If you have other coverage, (include Medicare or CHAMPUS), make sure you attach all payment statements or declination letters.**
- III. Attach all medical, dental 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 AmeriBen at:**

AmeriBen
P.O. Box 6577
Boise, ID 83707

Questions about Claims call:
AmeriBen
(855) 639-8679