CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: (888) 293-9229
Email: aciclaims@visit-aci.com

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in anapplication for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)		
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI	☐ FEMALE ☐ MALE
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP				
INSURED'S DATE OF BIRTH (MM/DD/YY)	INSURED'S PHONE NUMBER	INSURED'S MEMBER ID NUMBER	VISA TYPE: ☐F1 ☐J1 ☐OTHER _____	
VISA NUMBER	PASSPORT NUMBER	PASSPORT ISSUING COUNTRY	NOTE: If you hold a J-1 Visa, please attach a copy of your DS-2019 form from the University.	

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME		CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
CLAIMANT'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? Sickness Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:

   _____

   _____

   _____

   Date of Injury: _____

   b) Did injury occur at work? ☐ No ☐ Yes If yes, name of employer: _____

   c) Did injury occur during a motor vehicle accident? ☐ No ☐ Yes

   d) Did injury occur during practice or play of school-sponsored sports? ☐ No ☐ Yes If yes, please complete information about the sport below.

   Name of Sport: _____ ☐Intercollegiate ☐ Intramural/Club

   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ No ☐ Yes ☐ N/A (skip to Section 3)

   If yes, signature and title of health center official: _____

3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ No ☐ Yes ☐ N/A

   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION (CURRENT)

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes

   If yes, who is the Policyholder? ☐Self ☐ Parent ☐Spouse Name of Insurance Carrier: _____

   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

   Primary Insured's Name (Parent/Spouse/Self): _____

SECTION 4 –PRIOR INSURANCE COVERAGE

5. Did you have *prior* insurance which covered your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes

   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____

   Coverage Effective Date: _____ Coverage Term Date: _____

   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

   Primary Insured's Name (Parent/Spouse/Self): _____

Clear Form

SECTION 5 – ASSIGNMENT OF BENEFITS

6. Indicate below to whom payment is to be made:

☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.

☐ Expenses have been paid by the patient/insured. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Services, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature_____ Date _____

If student is under age 18, must be signed by a parent, guardian, or sponsor.

YOU CAN SUBMIT THIS COMPLETED FORM, ALONG WITH YOUR CURRENT CLASS SCHEDULE, BY MAIL OR FAX USING THE INFORMATION BELOW. ALTERNATIVELY, YOU MAY LOG INTO THE MEMBER PORTAL AT SECURE.VISIT-ACI.COM TO NOTIFY US OF A CLAIM.

Claims Mail:	Administrative Concepts, Inc. P.O. Box 4000, Collegeville, PA 19426-9000
Fax:	(610) 293-9299
Customer Service:	(888) 293-9229
Email	aciclaims@visit-aci.com

ITEMIZED BILL REQUIREMENTS

Hospital and Medical Bills

A fully itemized billing statement is required for claims payment consideration. The itemized billing statement must include the following:

- Patient's name
- Patient's date of birth
- Provider's name
- Provider's address
- Provider's tax identification number
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Amount charged for each procedure

Note: If your billing statement does not include this information, please contact the provider and ask them to send a copy to you to include with this form. (The fully itemized billing form is also known as a HCFA 1500, CMS 1500, UB04, and CMS 1450.)

Prescription Drug Receipts

A fully itemized prescription drug receipt is required for claims payment consideration. The prescription drug receipt must include:

- Pharmacy name
- Rx number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

Note: Please do not send a cash register receipt listing only the charges. You must send the full receipt or print-out that includes all of the above.

If you (or the medical provider) do not provide the Rx receipt as indicated above, your claim may be denied until the information is provided.