

STATE UNIVERSITY OF NEW YORK INTERNATIONAL STUDENT/SCHOLAR CLAIM FORM	HEALTH CENTER AUTHORIZATION Health Center Use Only • Do Not Use Red Ink _____ Authorization Stamp <small>(or SHC Reps Initials)</small>	CLAIMS DEPT. ADDRESS: HTH Worldwide PO Box 968 Horsham, PA 19044 Telephone: 888.350.2002 Fax: 888.250.4121 _____ Date of Service/Referral
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SEND COMPLETED CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO THE ABOVE ADDRESS.

If the student visits the student health center prior to seeking care outside of the student health center, the student's deductible will be waived, as long as the student health center stamps and authorizes this referral in blue or black ink. Your cooperation in completing all items on the claim form and attaching all required documentation will help us to process your claim quickly and accurately.

PLEASE TYPE OR PRINT • SEE REVERSE FOR COMPLETE INSTRUCTIONS • USE A SEPARATE CLAIM FORM FOR EACH PATIENT

PATIENT INFORMATION				PRIMARY POLICY HOLDER INFORMATION (on ID Card)				
NAME Last		First Middle		CERTIFICATE NUMBER		GROUP NAME	COLLEGE/ UNIVERSITY NAME	
BIRTH DATE		SEX	RELATION TO SUBSCRIBER			NAME Last		First Middle
		M F	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter			SUNY		
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO				ADDRESS				
NAME OF OTHER HEALTH INSURANCE COMPANY				CITY		STATE	ZIP CODE	
POLICY NUMBER of PRIMARY POLICY HOLDER				HOME PHONE NO. () area code		COLLEGE ID NUMBER		

MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan by the provider of service (the physician, clinic, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

Fully describe the medical problem (illness, accident or injury), when it began and area of body affected : _____

Was this medical expense the result of a motor vehicle accident? YES NO If yes, indicate date: Month ___ Day ___ Year ___

Was this condition or injury job related? YES NO If yes, have you filed for Workers' Compensation? YES NO

Was this condition or injury the result of or caused by the patient's participation in an intercollegiate sport? YES NO

Describe what happened that caused the condition or injury: _____

Were you referred by another physician or health care provider for these services? YES NO

If yes, please indicate referring physician or health care provider name and address (If referred by your **Student Health Center** please indicate) :

Dr: _____

DATE OF SERVICE (Mo/Day/Yr)	SERVICE PROVIDER (Name of Doctor, Lab, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL

Any person who knowingly presents a 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.

I certify that the information on this Member Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. SIGNATURE REQUIRED. This claim will be returned if this claim form is not signed.

Grand Total:
\$
Amount Paid:
\$

*Claim paid by Member?
 YES NO

X _____
 SIGNATURE OF SUBSCRIBER _____ DATE _____

*Note to Claims Department: If this form indicates that the Member has paid the provider please issue reimbursement to the Member.

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Dear SUNY Member:

In order to have the Injury and Sickness Deductible waived, you must have authorization from the campus Student Health Center for outside care. The completion of this form, with the proper authorization on the front of this form, will ensure your claim is adjudicated properly.

If a hospital, physician, ambulance company or other provider send their bill directly to you, we have no way of knowing about your claim until we receive your bill at HTH Worldwide. This Claim Form was developed for you to notify HTH Worldwide of any covered health services for which we have not already been billed directly and to provide us with additional information that may be needed in order to process your claim.

Please read the following instructions about how to report health care services.

We are happy to serve you.

PATIENT INFORMATION

INSURED INFORMATION (on ID Card)

Use this section to identify the patient and policyholder. Some of this information may be found on your HTH Worldwide ID card.

MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service which has not already been reported to HTH Worldwide by the provider of service (the physician, clinic, ambulance company, private duty nurse, etc.) Attach the itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance-forward bills or canceled checks are not acceptable.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL
7/9/01	John Wong, M.D.	Office Visit	Bronchitis	\$35.00
8/11/01	Pat Fogerty, M.D.	X-ray	Strain	\$57.00
GRAND TOTAL				\$92.00

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THE SERVICE TYPES LISTED BELOW

REGISTERED AND LICENSED VOCATIONAL NURSING SERVICES

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT

- Doctor's orders or prescriptions
- Purchase price

OUTPATIENT PRESCRIPTION DRUGS

- Duplicate pharmacy generated receipt (not register tape)
- Must include prescribing doctor's name, name of medication, date filled and amount charged, Rx number; date filled; form, strength & quantity dispensed

AMBULANCE

- Pick-up and delivery points
- Number of miles

ANESTHESIA

- Start Time
- End Time
- Surgical procedure
- Surgeon Name and address

PHYSICAL THERAPY

- Medical Records
- Prescription from referring physician indicating the number of visits prescribed

BILLS MUST BE ITEMIZED

Canceled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Provider taxpayer I. D. number
- Name of patient
- Date(s) of service
- Amount charged for each service
- Total Charge
- Diagnosis Code or reason for treatment
- Procedure Code(s) description of services performed