Mail the completed claim form packet to:

AmeriBen
P.O. Box 7186, Boise, ID 83707
800-953-1801

ACE American Insurance Company
Western Oregon University
SDH N00574090

CLAIM INFORMATION FORM

Name of University_____ **Insured Student's SS#**____/____/____ **Insured's Student I.D. #**____/___/____

Patient's Name: Last_____ **First**_____ **MI**____ **Patient's Sex: Male ☐ Female ☐**

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Insured Student's Name: Last_____ **First**_____ **MI**____

Home Address: Street:_____ **City:**_____ **State:**____ **Postal Code:**_____

Phone Number: (____)_____ **Patient's Date Of Birth:**_____

Complete This Section For Accident Or Injury:

Date of Accident:_____ **Place of Accident: Home ☐ Work ☐ Other (Describe):**_____

Describe Accident (What Happened):_____

Sports Injury: Yes ☐ No ☐ If Yes Indicate Sports Activity: Intercollegiate ☐ Intramural ☐ Club ☐ Other ☐

Describe Extent and Nature of Injury:_____

Complete This Section For All Other Medical Conditions:

Country Services Are Being Provided: _____ **Language Spoken:** _____ **Dialect:** _____

Describe Illness or Medical Problem:_____

When Did Present Illness or Medical Problem Begin? Date:_____

Have You Had This Illness or Medical Problem Before? No ☐ Yes ☐ If Yes, When? Date:_____

Present Attending Doctor or Clinic:_____ **Address:**_____

Any Other Attending Doctor or Clinic:_____ **Address:**_____

Family Doctor or Dentist or Clinic:_____ **Address:**_____

Name & Address of Hospital if Confined:_____ **Dates Of Confinement: From:** _____ **To:**_____

Are You, Your Spouse, or Child Insured as a Subscriber or a Dependent Under Any Other Group Plan, HMO, or Insurance Policy For Which You May Be Eligible For Benefits For This Condition? Yes ☐ No ☐ Is this plan an: HMO ☐ PPO ☐ Other_____

If Yes, Complete The Following Information: Insurance Company Name:_____

Address:_____ **Phone Number:**_____ **Policy Number:**_____

Subscriber Name:_____ **Subscriber Ss#;**_____

Subscriber's Employer Name:_____ **Address:**_____ **Phone#:**_____

Have You Been Insured With Another Health Insurance Plan Any Time During The Past 12-Month Period: Yes ☐ No ☐

If Yes, Complete The Following Information: Effective Date Of Coverage:_____ **Date Continuous Coverage Terminated:**_____

Insurance Company Name:_____

Telephone #:_____ **Address:**_____ **Policy Number:**_____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and believe true, correct and complete. Authorization must be given to the insurance company in order to facilitate a prompt equitable claims statement. I authorize payment directly to my medical provider(s) for charges incurred for all claims. 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. I also authorize Ameriben Solutions or its representatives to pay all bills in connection with this claim directly to the doctor, hospital, or any other persons rendering service, and such payment shall release Ameriben Solutions from liability as to amounts so paid. I hereby authorize any physician, hospital, company, employer or organization to release any information regarding the medical history, treatment, or benefits payable for this claim to Ameriben Solutions. A photocopy of this authorization shall be as valid as original.

I hereby certify that I have read the answers to all parts of this form & to the best of my knowledge believe the information is complete & correct as given herein.

For your protection, California law requires the following to appear on this form: "It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant"

Date:_____ **Student's Printed Name:** _____ **Student's Signature:** _____

Address While Traveling: _____

SUBMIT THIS CLAIM FORM WITHIN 90 DAYS OF SERVICE

Student Health Insurance Plan

INSTRUCTIONS FOR FILING A CLAIM

The Claim Packet that you submit to the insurance company must include the following:

1. **Your Completed claim form (First Page of this form).**
   - **A.** This form is to be completed by the student claiming benefit for self or dependent.
   - **B.** All questions must be answered.
   - **C.** The claim form must be signed and dated by the student/insured person.

2. **Itemized Billing Statements.**
   - **A.** Itemized statements must be presented on official letterhead of provider and must contain the following:
     - **i.** Patients name,
     - **ii.** Service date,
     - **iii.** Service rendered and charge, (must be converted to US dollars whenever possible),
     - **iv.** Diagnosis for each service.

3. **Paid Receipts.**
   - **A. If you or your school have already paid for the service:**
     - **i. Please forward your receipt(s) along with;**
     - **ii. a copy of the itemized bill,**
     - **iii. instruction for any applicable reimbursement, including:**
       - **a) to whom the check should be issued;**
       - **b) address to which the check should be mailed.**

MAIL THE COMPLETED CLAIM FORM PACKET TO:
AMERIBEN SOLUTIONS
P.O. Box 7186
Boise, ID 83707
1-800-953-1801 (in U.S. only)
1-208-344-7900

FOR CLAIM STATUS INFORMATION OR GENERAL QUESTIONS CONTACT:
AMERIBEN SOLUTIONS
1-800-953-1801 (in U.S. only)
1-208-344-7900

We recommend that you keep a photocopy of the claim packet for your records.