Christie Student Health

Student Health Insurance Claim Form*

Upon completion, send this form to the address on the back of your ID card.

School Name			Policy/Group Number
Christie Member ID	Member Name		Member Birthdate
Member Address (include ZIP Code) ☐Address is new			Member Daytime Phone Number
Patient name	Christie Patient ID	Patient Birthdate *(MM/DD/YYYY)*	Patient Relationship to Member ☐Self ☐Spouse ☐Child ☐Other
Patient Address	Patient Gender ☐Male ☐Female	Full time student? ☐No ☐Yes	Patient Expected Graduation Date
Patient Marital Status ☐Married ☐Single	Is patient employed? ☐No ☐Yes	Name & Address of Employer	
Is claim related to an accident? ☐No ☐Yes If Yes, date _____ time _____ ☐am ☐pm			Is claim related to employment? ☐No ☐Yes
Are any family members expenses covered by another group heath plan, group pre-payment plan, no fault auto insurance, Medicare or any federal, state or local government plan? ☐No ☐Yes	If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator.		
Member ID Number	Member Name	Member Birthdate	

To all providers of health care:
You are authorized to provide Christie Student Health or one of its affiliated companies ("Tufts Health Plan") and any independent claim administrators and consulting health professionals and utilization review organizations with whom Christie Student Health has contracted, information concerning health care advice, treatment or supplies provided he patient (including that relating to mental illness and/or AIDS/ARC/HIVE). This information will be used to evaluate claims for benefits. Christie Student Health may provide the employer named above with any benefit calculation used in payment of this claim for the purpose or reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
Patient's or authorized Person's Signature _____ _____ Date _____

I authorize payment of medical benefits to the physician or supplier of service
Patient or Authorized Person Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first consulted with you for this condition	If patient has had similar illness/injury, provide dates	If an emergency check here ☐ emergency
Name of referring physician (e.g. Public Health Agency)	For services related to hospitalization provide hospitalization dates Admitted Discharged		
Name & address of facility where services rendered (if other than home or office)			

Form Number: CSHP-20

Diagnosis or nature of illness or injury (please indicate primary and secondary diagnosis)

1.
2.
3.
4.

Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service	Procedure Code	Description of Service	Type of Service	Charges	Days or Units	Diagnosis Code	Administrative Use Only

Physician Name & Address (include ZIP Code)	Telephone Number	Enter the taxpayer identification number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identification number.
Patient Account Number		Total Charge $_____ Amount Paid $_____ Balance Due $_____
Physician or Supplier Signature	National Provider Identifier	Date

*Place of Service Codes:

1 – IH - Inpatient Hospital
2 – (OH) - Outpatient Hospital
3 – (O) - Office Visit
4 – (H) - Patient Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 – (NH) – Nursing Home
8 – (SNF) – Skilled Nursing Facility
9 - - Ambulance
0 – (OL) - Other Location
A – (IL) - Independent Laboratory
B - - Other Medical Surgical Facility
C – (RTC) – Residential Treatment Center
D – (STF) - Specialized Treatment Facility

Type of Service Codes:

1 – Medical Care
2 – Surgery
3 - Consultation
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 - Anesthesia
8 – Assistance at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
M – Alternate Payment for Maintenance Dialysis
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery

*Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.