



**Beech Street Preferred
Provider Network Plan**

**MAIL FORM TO:
AmeriBen/IEC Group
POB 7186
Boise, ID 83707**

**WHEN CALLING, GIVE THE
NAME OF YOUR SCHOOL
1-800-504-0142**



[HTTPS://SERVICES.AMERIBEN.COM](https://services.ameriben.com)
On Line Claims Look up Group Number:
0606038

Combined Life Insurance Company of New York

Name of Institution: **TEMPLE UNIVERSITY 2008-2009** Policy No: **CUH201523**

ABOUT INSURED STUDENT:	Name:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	School Address: _____ Street, P.O. or Apt #, City State Zip	School Phone #:		
	Home Address: _____ Street, P.O. or Apt #, City State Zip	Home Phone #:		

COMPLETE IF CLAIM IS FOR INSURED DEPENDENT	<input type="checkbox"/> My Spouse(Name): _____ DOB: _____
	<input type="checkbox"/> My Child (Name): _____ DOB: _____
	Is child married? <input type="checkbox"/> yes <input type="checkbox"/> no Is child employed? <input type="checkbox"/> yes <input type="checkbox"/> no Is child a full time student? <input type="checkbox"/> yes <input type="checkbox"/> no

ABOUT THE CLAIM	COMPLETE IF INJURY	DATE: __/__/__ WHERE DID THE INJURY OCCUR? _____ PLEASE GIVE FULL DETAILS OF ACCIDENT _____ _____
	COMPLETE IF SICKNESS	WHEN DID SYMPTOMS BEGIN? _____ DESCRIBE THE SICKNESS _____ DATE PATIENT FIRST SOUGHT TREATMENT FOR THIS SICKNESS: _____ NAME OF DOCTOR: _____ HAVE YOU HAD THIS CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, SHOW DATES OF PRIOR TREATMENT): _____ IF PREGNANCY, WHAT IS THE DATE OF LAST MENSTRUAL PERIOD?: _____

ABOUT OTHER INSURANCE	Have you had other insurance prior to the effective date of this school's insurance, including coverage through a school, within the past 12 months? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, complete the following:		
	Name of Prior Insurance Company: _____ Policy Number: _____		
	Effective Date of Prior Policy: _____ Cancellation/Termination of Prior Policy: _____		
	IS THE PATIENT CURRENTLY COVERED BY ANY OTHER MEDICAL INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF ANSWER IS YES, PLEASE GIVE COMPLETE INFORMATION ABOUT YOUR OTHER INSURANCE PLAN BELOW		
	Name & Address of the Other Insurance Company	Name of the Employer, Group or School Providing Insurance	Policy Number and Effective Dates

COMPLETE IF REQUIRED BY SCHOOL

HEALTH CENTER REFERRAL	DATE SEEN AT HEALTH CENTER _____ AUTHORIZED SIGNATURE _____
	I DID NOT GO TO THE HEALTH CENTER BECAUSE: (CHECK ONE) <input type="checkbox"/> I WAS NOT IN THE AREA <input type="checkbox"/> IT WAS AN EMERGENCY <input type="checkbox"/> THE HEALTH CENTER WAS CLOSED

TO BE COMPLETED BY POLICYHOLDER/SCHOOL ADMINISTRATOR

If an accident occurred during an activity sponsored by your organization, please describe the activity, how the accident occurred and specify the date of the accident:

Comments/Remarks: _____
I Certify that the Foregoing Information is True and Correct: _____

Authorized Signature

REVERSE SIDE MUST BE COMPLETED AND SIGNED OR CLAIM FORM WILL BE RETURNED

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician who has examined or treated me, any hospital or medically related facility where I have been confined, treated or examined, or any other individual or organization which has provided me health care services to give any and all information about my medical history, mental or physical condition, or treatment to the Insurance Company named on the reverse side or its authorized representative, upon its request, for the purpose of determining my eligibility for the benefits I have requested. I also authorize any employer, insurer or other organization having non-medical records or information about me to give any and all such information to the Insurance Company named on the reverse side or its authorized representative, upon its request, for the purpose of determining my eligibility for the benefits I have requested. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization shall remain valid for the duration of my claim.

Insured's Signature

Date of Signature

Signature of Patient (if other than Insured Person and not a minor)

Date of Signature

**IF YOU HAVE ALREADY PAID - ATTACH PAID RECEIPTS AND SIGN BELOW
PAID RECEIPTS MUST BE ATTACHED TO THIS CLAIM FORM TO RECEIVE DIRECT PAYMENT.**

I have already made payment to the Hospital or Doctor. Please make payment directly to me.

Claimant's Signature

Date of Signature

TO AVOID DELAY IN CLAIM PROCESSING, FOLLOW THESE GUIDELINES:

The Student (not the doctor or hospital) must complete and submit the Student Insurance Claim Form immediately. **NO CLAIM WILL BE PROCESSED UNLESS THIS FORM IS FULLY COMPLETED AND SIGNED.** Fill in all blanks and mail this form to **AmeriBen/IEC Group POB 7186, Boise, ID 83707.** Do not wait to accumulate bills - we'll match them up with your claim.

1. In addition to this claim form, submit itemized bills from physicians, hospitals, and other medical service providers as soon as you receive them. Be certain that they are "itemized" with the diagnosis on them. The Insurance Company cannot pay from "balance due" or "carryover" statements.
2. Carefully complete the Sports questions. Sports injuries are often payable under a separate policy. Sports injuries are those that occur during the play, practice or travel to or from regularly scheduled, school sponsored athletic activities.
3. Carefully complete the other insurance questions.

FAILURE TO COMPLETE ALL PORTIONS OF THE CLAIM FORM IS A COMMON CAUSE OF DELAY IN CLAIMS PROCESSING.

IMPORTANT: Itemized bills are required to process all claims. Claims cannot be processed from a statement showing only the total balance due. On any additional bills, the claimant's name and the diagnosis must be clearly indicated on each bill. If your treatment extends over a period of time, send bills periodically. Do not accumulate your bills for submission at the end of the year!

Any person who knowingly and with intent to defraud 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTE: YOU MUST FILL OUT ONE CLAIM FORM FOR EACH SICKNESS OR INJURY.