

INDIANA UNIVERSITY HEALTH CENTER CLAIM FORM

(USE THIS FORM ONLY FOR SERVICES RENDERED
AT THE IU HEALTH CENTER and IUPUI HEALTH SERVICES)

Insurance Plan (check one)			
<input type="checkbox"/> SAA (812849)	<input type="checkbox"/> International (812849)	<input type="checkbox"/> Grad/Undergrad (890423)	<input type="checkbox"/> School of Medicine (812801)
Student Name (as it appears on your ID card)		Patient Name (if not the student)	
ID Number (as it appears on your ID card)		Patient Date of Birth / /	
Address	City	State	Zip
Telephone Number			

PLEASE KEEP COPIES OF ALL DOCUMENTS FOR YOUR RECORDS.

To expedite processing, please include the following

- Is the Walk-out statement from the IU Health Center included? Yes No

- Are the detailed pharmacy receipts showing drug name, dosage, and cost included (if applicable)? Yes No

- Is your name and ID number clearly listed on each page? Failure to do so may result in a delay in reimbursement. Yes No

- Is this claim a result of an auto, work, or intercollegiate sports accident? Yes No

If yes, provide details: _____

AUTHORIZATION OF FOR MEDICAL INFORMATION

To all Physicians, Hospitals, and other Professionals:

You are authorized to provide Aetna Student Health and any independent consulting health professional or auditor acting on its behalf or that of the insurance company information concerning health care, advice, treatment or supplies provided to the patient, including that relating to mental illness or substance abuse. This information will be used for evaluating and administering claims for benefits. This authorization is valid for the term of coverage. I agree that a photocopy is as valid as the original.

Signature _____ Date _____
 (If under 18, parent or guardian signature)

Please return this form and applicable attachments to:

COPÆ.

P.O. Box 15708
 Boston, MA 02215

Instructions for Filing IU Health Center Claims with 5YrbU

At the IU Health Center students are required to pay the charges for all of the services received. The IU Health Center will issue a Walkout Statement to you indicating the services you have received.

To submit the Walkout Statement for services received at the IU Health Center to 5YrbU, please use the following instructions:

1. Write your Member Number (as it appears on your 5YrbU ID card) at the top of the IU Health Center Walkout Statement.
2. If you are submitting prescription claims, please include the 1 x 3 receipt attached to the prescription bag. Write your Member number (as it appears on your 5YrbU ID card) on the prescription receipt. Please note that if you fail to submit the receipt you will not be reimbursed for your prescriptions.
3. For your records, make a copy of the IU Health Center Claim Form, the IU Health Center Walkout Statement, and your prescription receipts (if applicable).
4. Place one copy of the IU Health Center Claim Form, the IU Health Center Walkout Statement, and any prescription receipts (if applicable) in an envelope.
5. Address the envelope to 5YrbU using the following address:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215
6. Put your return address on the envelope, along with a stamp, and place it in the mail.

If you have any questions, please contact the Student Health Coordinator at studenhc@indiana.edu.