

CLAIM FORM

Please return this form and any attachments to:

AETNA LIFE INSURANCE COMPANY

Illinois State University
 Office of Student Health Insurance
 Campus Box 2541
 Normal, IL 61790
 Telephone: (309) 438-2515

Noncompletion of this form may result in delay/denial.
 If other insurance exists, attach payment/denial

School Illinois State University – Policy Number 711123			
Student Name			
University ID Number		Patient Date of Birth / /	
Address	City	State	Zip
Telephone Number			

PAYMENT WILL BE MADE TO PROVIDER UNLESS RECEIPT IS SUBMITTED WITH CLAIM.

Complete this section for accident claim.	Complete this section for sickness/maternity/RX/other claim.
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Date of Injury: _____

 Describe how and where Accident occurred: _____

Did accident occur at work? Yes No

If Injury is due to play or practice of sports,
 Which Sport: _____

Intramural

Recreational/other

NCAA Intercollegiate Sports (these claims
 will be forwarded to ISU Athletic Insurance)

Date of condition: _____
 Date symptoms first noticed: _____
 What is exact nature of the condition? _____

Have you ever had the same or similar condition? _____

If yes, date of first treatment: _____

Date of last treatment: _____

Name of physicians: _____

This section must be completed	SINCE YOUR STUDENT POLICY HAS A COST SHARING LIMITATION (SEE BROCHURE), WE NEED THE FOLLOWING INFORMATION ON <u>EACH</u> CLAIM SUBMITTED.	
	• Do you have other illness/accident insurance, either group or individual?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• Does either parent cover you on a policy of theirs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If this claim relates to a motor vehicle accident, are any medical benefits payable on a vehicular insurance policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Insurance: _____	Name of Parent or Policyholder: _____
	Address of Insurance: _____	Employer of Policyholder: _____
Phone Number of Insurance: _____	Policy Number: _____	
	Phone Number of Policyholder: _____	

AUTHORIZATION FOR MEDICAL INFORMATION

To all Physicians, Hospitals, and other Professionals:

You are authorized to provide Chickering Claims Administrators, Inc. 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 _____
 (If under 18, parent or guardian signature)

Date _____