Relation

Relation Insurance Services
P.O. Box 25936
Overland Park, KS 66225

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
INSURED'S DATE OF BIRTH (MM/DD/YY) / /	☐ FEMALE ☐ MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME		CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
CLAIMANT'S DATE OF BIRTH (MM/DD/YY) / /	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? ☐ Sickness ☐ Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:

   Date of Injury: _____

   b) Did injury occur at work? ☐ No ☐ Yes If yes, name of employer: _____
   c) Did injury occur during practice or play of school-sponsored sports? ☐ No ☐ Yes If yes, please complete information about the sport below.
   Name of Sport: _____ ☐ Intercollegiate ☐ Intramural/Club
   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ No ☐ Yes ☐ N/A (skip to Section 3)
   If yes, signature and title of health center official: _____
3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ No ☐ Yes
   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____
   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____
   Primary Insured's Name (Parent/Spouse/Self): _____

SECTION 4 – ASSIGNMENT OF BENEFITS

5. Indicate below to whom payment is to be made:
   ☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.
   ☐ Expenses have been paid by the patient/insured. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Administrators, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature_____ Date _____

If student is under age 18, must be signed by a parent or guardian.

IMPORTANT: This form must be completed and returned to Relation Insurance Administrators within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements on page 2).

YOU CAN SUBMIT THIS COMPLETED FORM BY MAIL OR FAX USING THE INFORMATION BELOW. CLAIMS ARE NOT ACCEPTED VIA EMAIL.

Claims Mail: Relation Insurance Services, P.O. Box 25936, Overland Park, KS 66225
Claims Fax: (800) 346-9169
Customer Service: (206) 909-8550 WA / (503) 729-7447 (OR)
Customer Service E-mail: claims@relationinsurance.com

ITEMIZED BILL REQUIREMENTS

Hospital and Medical Bills

A fully itemized billing statement is required for claims payment consideration. The itemized billing statement must include the following:

- Patient's name
- Patient's date of birth
- Provider's name
- Provider's address
- Provider's tax identification number
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Amount charged for each procedure

Note: If your billing statement does not include this information, please contact the provider and ask them to send a copy to you to include with this form. (The fully itemized billing form is also known as a HCFA 1500, CMS 1500, UB04, and CMS 1450.)

Prescription Drug Receipts

A fully itemized prescription drug receipt is required for claims payment consideration. The prescription drug receipt must include:

- Pharmacy name
- Rx number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

Note: Please do not send a cash register receipt listing only the charges. You must send the full receipt or print-out that includes all of the above.

If you (or the medical provider) do not provide the Rx receipt as indicated above, your claim may be denied until the information is provided.