

# Student Medical Insurance Plan Claim Form



**Southern**  
Illinois University  
**Carbondale**

visit us on the web: [www.siu.edu](http://www.siu.edu)

## Return completed form to:

Student Health Center  
Student Medical Insurance Office  
Mail Code 6740  
374 East Grand Avenue  
Carbondale, IL 62901

Ph: 618/453-4413

### IMPORTANT - YOUR CLAIM WILL BE DENIED IF THIS FORM IS NOT FULLY COMPLETED

Name of the student: (Last, First, MI)		Dawg Tag#		Date of Birth	Age
Permanent home address: (Number, Street, City, State, and ZIP Code)				Phone Number:	
Local home address: (Number, Street, City, State, and ZIP Code)				Phone Number:	
1. Nature of injury or condition:					
2. When did symptoms first appear or accident happen? Date: _____ Time: _____			3. If pregnant, state first day of last menstrual period:		
4. If injury, describe how and where accident occurred - give complete details (use additional pages if necessary):					
5. If a motor vehicle injury, list names of all drivers and companies insuring all drivers and/or vehicles:					
6. If injured during practice or play of sports, what sport was involved? Check One: <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate athletics <input type="checkbox"/> Other					
7. Have you suffered the same or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No			8. Dates of prior medical care for this condition: From: ___/___/___ To: ___/___/___		
9. Name and address of hospital/clinic:			10. Name and address of attending physician(s)		
<b>Other insurance</b>					
11. Do you have any other insurance - group, individual, or through your parent(s), guardian, or spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes give the following data:</b>					
Name of the company:		Name of policy holder:		I.D. number:	
Company address:		12. Father's name:			
Company Phone number:		13. Father's employer's name and address:			
Group number:		14. Mother's name:			
Policy number:		15. Mother's employer's name and address:			

### DISCLOSURE OF AUTHORIZATION (Patient/student's responsibility to complete)

I understand this form must be completed and returned with six months from the date of onset illness/injury to the Student Medical Insurance Office accompanied by all bills incurred to that date. I understand that failure to fully complete the information requested herein will result in permanent denial of my claim. Upon presentation of the original copy of this signed authorization, I authorize any medical, health care professional, hospital, clinic, or other medical or medically related facility, government agency, parents, guardian, or spouse or other person or firm to provide information including but not limited to copies of bills and records, concerning advice, care or treatment provided to me including, without limitation, information relating to mental illness, use of drugs or alcohol, or insurance coverage, to Southern Illinois University Carbondale representatives involved in evaluating, determining or administering claims for medical benefits for me. I understand that I will receive a copy of this authorization upon request. This authorization is valid from date signed through the term coverage of the policy or during the period to process the claims. This authorization may be revoked, in writing, but such revocation may affect my right to coverage.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_