

SEND COMPLETED FORM TO:

NAHGA Claim Services

PO Box 189

Bridgton, ME 04009-0189

For questions call: 877.497.4980

Fax: 207.647.4569

Email: eija@nahga.com

IMPORTANT!

THIS IS FOR SICKNESS CLAIMS ONLY!

- ◆ One claim form will be required per school year.
- ◆ All eligible expenses must be submitted within one year from the date of service.
- ◆ All charges must be filed with your primary insurance first before benefits will be considered.
- ◆ Please be sure you have provided your medical providers with a copy of your Certificate/Summary of Benefits so your provider can bill directly!



SECTION 1: Student Statement

- (1) Your Institution: _____ (2) Coverage Number: _____
- (3) Student Name (First and Last): _____
- (4) Student ID Number: _____
- (5) Street Address, City, State and Zip (all insurance info/requests will be sent to this address):

- (6) Phone Number: _____ (7) Email Address: _____
- (8) Date of Birth: _____ (9) Gender: Male Female Neutral
- (10) I am a: _____ Domestic Student _____ International Student
- (11) Reason for seeking medical treatment: _____
- (12) Were you referred by Student Health Services? Yes _____ No _____

SECTION 2: Insurance Statement

If the student is under 26 years old and is insured, all the charges must be filed with the other insurance carrier first and copies of the Explanation of Benefits (EOBs) will be required for all charges submitted. INCOMPLETE CLAIM FORMS WILL BE RETURNED AND DELAY THE CLAIMS PROCESS.

Are you insured under a health plan? Yes _____ No _____ If yes, please complete the information below:

Insurance Company Name: _____

Insurance Company Phone Number: _____

Insurance Plan ID Number: _____

Is this a Government Funded Plan (i.e. Medicaid or Military Insurance) Yes: _____ No: _____

To any medical care provider, medical care facility, Insurer, government-sponsored health plan or employer: I grant authorization (*while my claim is pending*) of the release of any medical information about me to NAHGA Claim Services and its representatives, EIIA, and other persons or groups performing business or legal services relating to my claim. This applies to all information necessary to determine the eligibility of my claim. A copy of this authorization (*one of which will be given to me by NAHGA Claim Services upon my request*) will be valid as this one for a period of 24 months from the date of my signature. I may revoke this authorization by written request to NAHGA Claim Services.

I certify that the above information provided by me in support of this claim is true and correct. I understand that if I knowingly misrepresent or falsify essential information requested by this form I may, upon conviction, be subject to fine or imprisonment.

New York: 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.

Insured Student's Signature: _____ Date: _____

Participating Institution's Authorization: _____ Date: _____

FOR PRIVACY POLICY INFORMATION PLEASE GO TO: www.eija.org

For plan information, summary of benefits, claim forms or other information please go to: www.eija.org and click on STUDENT INSURANCE and find your school.