MEDICAL EXPENSE
Claim Form and Instructions - Student Blanket

GeoBlue
GeoBlue is the trade name of Worldwide Insurance Services, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

1. PATIENT INFORMATION

Member ID	*Please enter the 12 digit Group ID Number as shown on your card*	G	T	B	9	9	9	9	N	W	B	K	T

Patient's Name *(Given Name, Family Name)*	Patient's date of birth *(MM/DD/YYYY)*	Patient's Gender
		◯ Male ◯ Female
Name of Insured Member *(Given Name, Family Name)*	Insured's date of birth *(MM/DD/YYYY)*	Patient's Relationship to Insured
		◯ Self ◯ Spouse ◯ Child
Name of Plan Program Sponsor	Insured's current mailing address	

Member Email	Member Phone Number

2. OTHER HEALTH INSURANCE

Is the patient covered under other health insurance?	◯ YES ◯ NO	***If YES**, please complete this section*
Name and address of other insurance company		Name of the Policy Holder

Policy Holder's Date of Birth *(MM/DD/YYYY)*	Policy or identification number of other coverage	Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/DD/YYYY)*

3. DIAGNOSIS – *describe illness, injury or symptoms requiring treatment*

IF IN AN ACCIDENT

Date of Accident *(MM/DD/YYYY)*		Place of Accident			
Date of Doctor/Hospital Visit *(MM/DD/YYYY)*		Was the injury a result of participation in an Intercollegiate Sport?	◯ YES ◯ NO	Was this an Auto Accident?	◯ YES ◯ NO
Description/Details of Injury *(attach additional notes if necessary)*					

IF SICKNESS/ILLNESS

Onset Date of Symptoms *(MM/DD/YYY)*		Date of Doctor/Hospital Visit *(MM/DD/YYYY)*	
Have you had this Sickness/Illness before?	◯ YES ◯ NO	If YES, when was the last occurrence and/or doctor/hospital visit?	
Description/Details of Illness *(attach additional notes if necessary)*			

4. CHARGES – *use a separate line to list each type of service or provider and attach itemized bills for all services*

Name, City & Country of provider making charge	Diagnosis	Description of service *(Office Visit, X-ray, Prescription, etc.)*	Dates of Service *(MM/DD/YYYY)*	Charges *(Please indicate currency)*

5. CLAIM PAYMENT REIMBURSEMENT

Have these doctor/hospital bills been paid by you?	◯ YES ◯ NO	If YES, payment will be made to Primary Insured via Check *(payable in US$ and mailed to the address indicated above)*
If NO, do you authorize payment to the provider of service for medical services claimed?	◯ YES ◯ NO	*If payment is to be paid to an international provider, please ensure bank information is on the provider invoice. See Filing Instructions for non-international provider payments*

6. SIGNATURE

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to GeoBlue and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Please see the back of this form for important information.

Signature of Insured member or patient		Date	

FRAUD NOTICE

General Fraud Warning –
Any person who knowingly and with intent to defraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AUTHORIZATION FOR ASSIGNMENT

Authorization for Assignment –
All payments will be made to the Primary Insured if the doctor/hospital bills have been paid by you. If you would like a third party to receive reimbursement for covered expenses under this policy, you must request an Authorization for Assignment from GeoBlue Member Services.

Authorization for Assignment of Benefits is voluntary. Any documentation accompanying a payment or otherwise could contain federal and/or state Protected Health Information and other protected private or financial information. Protected Health Information means health data that could be used to individually identify you including your name, address and specific medical material and facts.

INSTRUCTIONS FOR FILING A CLAIM

The following steps will assist you in filing claims. **Please note that submitting an incomplete form will result in the delay of processing your claim.**

For Parts 1 – 4 of the claim form:

- Please submit a **separate claim form** for each patient
- Please be as descriptive as possible

Submitted bills must be **itemized** – canceled check, cash register receipts and non-itemized "balance due" statements **cannot be** processed.

- An Itemized bill is a full description of all actual charges and each itemized bill must include:
  - Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), name of patient, date(s) of service, amount charged for each service described, diagnosis or reason for treatment
- Submitted bills for Prescriptions should include the name of the drug, the quantity dispensed and the dosage.

To accurately complete Part 5, Payment Details:

- Payments are made to the **Primary Participant/Insured Member on the plan**. Payments cannot be made directly to a dependent or to a third party (other than the medical provider).
- **If paying international provider,** invoice must include bank information
- Providers in the USA, Puerto Rico and the U.S. Virgin Islands should bill their local Blue Cross Blue Shield Plan directly.

SEND COMPLETED CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO THE APPROPRIATE ADDRESS BELOW

CLAIMS INCURRED INSIDE the U.S., Puerto Rico, and U.S. Virgin Islands	**CLAIMS INCURRED OUTSIDE** the U.S., Puerto Rico, and U.S. Virgin Islands
GeoBlue **P.O. Box 21974 Eagan, MN 55121** Claims Submission Fax: **1.610.482.9623** Claims Submission Email: **claims@geo-blue.com**	**GeoBlue** **Claims Department** **PO Box 1748** **Southeastern, PA 19399-1748** Claims Submission Fax: **1.610.482.9623** Claims Submission Email: **claims@geo-blue.com**

24/7 Member Services:	Outside the U.S.: **+1.610.254.5830**	Toll Free Within the U.S.: **1.844.412.6403**