

# CLAIM FORM

Telephone: 1 (866) 679-0831  
HCH Administration/  
Academic Health Plans

## USE THIS ADDRESS TO MAIL:

Student Insurance Office  
Health Services, Rm 201  
Northern Illinois University  
DeKalb, Illinois 60115-2879  
(815) 753-0122

## UniCare Life and Health Insurance Company of the Midwest

This form must be fully completed, signed by the claimant, and returned to this office within 12 months of the date of service, or claim processing may be delayed/denied.

|  |                                     |                              |     |
|--|-------------------------------------|------------------------------|-----|
| School<br><b>NORTHERN ILLINOIS UNIVERSITY—Policy Number 141251</b> |                                     |                              |     |
| Student Name   |                                     | Patient Name (if different)  |     |
| Student Social Security Number                                     | Student ID Number<br>(if different) | Patient Date of Birth<br>/ / |     |
| Address  | City                                | State                        | Zip |
| Telephone  |                                     |                              |     |

|                                       |  |  |                             |
|---------------------------------------|--|--|-----------------------------|
| <b>This section must be completed</b> | SINCE YOUR STUDENT POLICY HAS A COST SHARING LIMITATION (SEE BROCHURE), WE NEED THE FOLLOWING INFORMATION ON EACH CLAIM SUBMITTED. |  |                             |
|                                       | Do you have other health insurance, either group or individual?  | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
|                                       | Does either parent cover you on their policy?  | <input type="checkbox"/> Yes             | <input type="checkbox"/> No |
|                                       | Name of Insurance: _____   | Policy Number or Policyholder SSN: _____ |                             |

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

#### Complete this section for accident/injury claim.

#### Complete this section for sickness/other claim.

Exact nature of injury \_\_\_\_\_

Date of Sickness \_\_\_\_\_

\_\_\_\_\_

Date symptoms first noticed \_\_\_\_\_

Date and hour of occurrence \_\_\_\_\_

What is exact nature of sickness? \_\_\_\_\_

If injury is due to play or practice of an NIU sport, which NIU sport? \_\_\_\_\_

\_\_\_\_\_

Is condition work related?  Yes  No

Have you ever had the same or similar  Yes  No

Is condition due to auto accident? If Yes,  Yes  No  
please attache auto voucher.

condition? If yes, date of first treatment \_\_\_\_\_

Were you treated at the NIU Health Center  Yes  No  
Service for this condition?

Date of last treatment \_\_\_\_\_

Were you treated at the NIU Health  Yes  No  
Service for this condition?

### AUTHORIZATION FOR MEDICAL INFORMATION

#### To all Physicians, Hospitals, NIU Health Service and other Professionals:

You are authorized to provide UniCare Health Insurance Company of the Midwest and/or HCH Administration, 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.

Claimant Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if 18 years or older—parent/guardian if younger)