

STUDENT MEDICAL INSURANCE REFERRAL FORM



INSURED INFORMATION				
Last Name:	First Name:	Middle Initial:	Gender:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Student Insurance ID# or Social Security#:	Home phone #:		Birth date:	
	()		/ /	
Street address:	P.O. Box:	City:	State:	ZIP Code:

PATIENT INFORMATION (IF DIFFERENT FROM ABOVE)				
Last Name:	First Name:	Middle Initial:	Gender:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address:	City:		State:	
P.O. Box:	ZIP Code:		Birth date: / /	
Patient's relationship to student:				
<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Other <i>(Please specify)</i>	

ACCIDENT INFORMATION				
<input type="checkbox"/> Work Accident	<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Intercollegiate Sport Accident	<input type="checkbox"/> Intramural Sport Accident	<input type="checkbox"/> Other
Details of Accident:				Date Occurred:
				/ /

INJURY / SICKNESS INFORMATION				
Have you suffered the same or a similar condition in the past?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, and if you were treated for it, please give the name and	
address of the Physician who treated you.		Physician's Name:		
Physician's Address:			Date Treated: / /	
I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER MEDICAL PROVIDER TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM TO UNITEDHEALTHCARE INSURANCE COMPANY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.				
Insured's Signature:			Date:	

OTHER INSURANCE INFORMATION				
(If the patient is covered by another insurance plan, please complete the following.)				
Name of person carrying other insurance:	Subscriber # or Social Security#:		Name of other insurance carrier:	
Other Insurance Policy #:	Other Insurance Phone #:		Policy Holder Date of Birth:	
	()		/ /	
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.				
Insured's Signature:			Date:	

STUDENT HEALTH SERVICES REFERRAL				
Did Receive A Referral:	Health Services was Closed:	This was an Emergency:	I was more than 50 miles from campus:	Other <i>(Please explain):</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE **STUDENTRESOURCES**

- Clip, do not staple, all bills to the complete form and mail them to UnitedHealthcare **StudentResources** at P.O. Box 809025 Dallas, TX 75380-9025
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare **StudentResources** in a timely manner.