

# 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					
Description of Injury/Sickness:					
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:    /    /	
<p><b>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.</b></p>					
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:	
		(    )		/    /	
<p><b>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.</b></p>					
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:	I am pregnant:	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	<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.