

HUDSON HEALTH CENTER
STUDENT MEDICAL INSURANCE PRESCRIPTION SUBMISSION FORM

Return this form with copies of all prescription receipts received from the Student Health Service

Mail completed form to:
UNITED HEALTHCARE STUDENT RESOURCES
PO BOX 809025
DALLAS, TX 75380-9025

Policy#: 2008-1103-1

School Name: Ohio University

Student Name: _____ **Male** _____ **Female** _____

Social Security#: _____ **Student PID#:** _____ **Date of Birth:** _____

Address Where You Would Like Reimbursement Check To Be Sent:

(Street)

(Apt.#)

(City)

(State)

(Zip Code)

NOTE TO CLAIMS EXAMINER: Any claims accompanying this submission form should be paid directly to the student and sent to the address above.