WELLFLEET STUDENT

Berkeley SHIP student health insurance plan

MEDICAL CLAIM FORM

PLEASE ATTACH ITEMIZED BILL AND SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA 93718-5018 Phone: 1-833-302-9785. Fax: (559) 499-2464.

1. Group Number
W01

2. Group Name
University of California, Berkeley

STUDENT INFORMATION

3. Name of student *(insured)* | **Date of Birth** | **Subscriber ID**

4. Address of student **Street** **City** **State** **Zip Code**

Are you or any member of your family covered under another Group Plan providing medical benefits? ☐ **Yes** ☐ **No**

REMARKS:

If you have checked Yes, please provide policy number _____
Effective date _____
Name of insured _____
Name and address of insurance company _____
_____
Name and address of the employer or organization which sponsors the coverage _____
_____

MEDICAL INFORMATION

5. This claim is for ☐ **Student** ☐ **Spouse or Domestic Partner** ☐ **Child**

6. This claim is for
☐ **Illness**
☐ **Injury** **Date:** _____
Briefly describe how injury occurred:

Does this claim involve a work-related illness or injury? ☐ **Yes** ☐ **No**
Does this claim involve a Motor vehicle injury? ☐ **Yes** ☐ **No**
☐ **Other:** _____

IF THIS CLAIM IS FOR YOUR DEPENDENT, COMPLETE THIS SECTION

7. Name of your dependent | **Date of Birth**

8. Is dependent employed? ☐ **Yes** ☐ **No** **Name of dependent's employer**

9. Address of employer **Street** **City** **State** **Zip Code**

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original. If applicable, I hereby assign my rights to benefits to, and authorize payment directly to, the Physician indicated on the attached bill, for those benefits to which the Plan Member is entitled, provided the benefits paid do not exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this assignment.

_____ _____
Signed (Patient or Parent if Minor) **Date**

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.