CHP
Consolidated Health Plans

Student Insurance Claim Form

Upon Completion, mail this form to:

Consolidated Health Plans, Inc.
2077 Roosevelt Ave
Springfield, MA 01104
Fax (413) 733 - 4612

School Name:

Student's Name:	Member ID Number:	Date of Birth:
Student's Address City State Zip		Telephone Number

Is this claim for your dependent? ☐ Spouse ☐ Child

Dependent's Name: Date of Birth

Do you, your dependents, or your parents have any other insurance or medical plan that covers this condition? ☐ YES ☐ NO

If Yes, Please enter the name of the insurance company: _____

1. For an Annual / Routine Examination: ☐ YES ☐ NO

2. For an Illness / Prescriptions:

Please describe symptoms: _____

Dates of Illness _____

Date you first consulted a physician for this illness _____

Have you ever sought treatment for this illness in the past? ☐ YES ☐ NO

If Yes, please describe past treatments and Dates: _____

3. For an injury:

Please describe where and how injury occurred _____

Date of Injury: _____

Was the injury a result of an auto accident? ☐ YES ☐ NO

Were you injured while working on the job? ☐ YES ☐ NO

Were you injured during the practice or play of an intercollegiate sport? ☐ YES ☐ NO

If Yes, signature of Athletic Director _____

Have you ever sought treatment for this injury in the past? ☐ YES ☐ NO

If Yes, please describe past treatments and dates: _____

Were you treated by Student Health Services and referred for this condition? ☐ YES ☐ NO

Seen by: _____

If not referred, why: _____ (Away from School: Winter/Spring/Summer Break, Other (attach explanation)

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Consolidated Health Plan or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just a valid as the original. I authorize Consolidated Health Plans or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the 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 hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

Signature of Claimant

Date