CLAIM FORM

AETNA LIFE INSURANCE COMPANY

Noncompletion of this form may result in delay/denial.
If other insurance exists, attach payment/denial

Please return this form and any attachments to:

Illinois State University
Office of Student Health Insurance
Campus Box 2541
Normal, IL 61790
Telephone: (309) 438-2515

School
Illinois State University – Policy Number 711123

Student Name

Student Social Security Number | Patient Date of Birth / /

Address | City | State | Zip

Telephone Number

PAYMENT WILL BE MADE TO PROVIDER UNLESS RECEIPT IS SUBMITTED WITH CLAIM.

Complete this section for accident claim.

Date of Injury: _____

Describe how and where Accident occurred: _____

Did accident occur at work? ❑ Yes ❑ No

If Injury is due to play or practice of sports,

Which Sport: _____

Intramural ❑

Recreational/other ❑

NCAA Intercollegiate Sports (these claims will be forwarded to ISU Athletic Insurance) ❑

Complete this section for sickness/maternity/other claim.

Date of condition: _____

Date symptoms first noticed: _____

What is exact nature of the condition? _____

Have you ever had the same or similar condition? _____

If yes, date of first treatment: _____

Date of last treatment: _____

Name of physicians: _____

This section must be completed

SINCE YOUR STUDENT POLICY HAS A COST SHARING LIMITATION (SEE BROCHURE), WE NEED THE FOLLOWING INFORMATION ON EACH CLAIM SUBMITTED.

- Do you have other illness/accident insurance, either group or individual? ❑ Yes ❑ No
- Does either parent cover you on a policy of theirs? ❑ Yes ❑ No
- If this claim relates to a motor vehicle accident, are any medical benefits payable on a vehicular insurance policy? ❑ Yes ❑ No

Name of Insurance: _____

Address of Insurance: _____

Phone Number of Insurance: _____

Name of Parent or Policyholder: _____

Employer of Policyholder: _____

Policy Number or Policyholder SSN: _____

Phone Number of Policyholder: _____

AUTHORIZATION FOR MEDICAL INFORMATION

To all Physicians, Hospitals, and other Professionals:

You are authorized to provide Chickering Claims Administrators, Inc. and any independent consulting health professional or auditor acting on its behalf or that of the insurance company information concerning health care, advice, treatment or supplies provided to the patient, including that relating to mental illness or substance abuse. This information will be used for evaluating and administering claims for benefits. This authorization is valid for the term of coverage. I agree that a photocopy is as valid as the original.

Signature _____ Date _____
(If under 18, parent or guardian signature)