

PRINCETON UNIVERSITY CLAIM FORM

Please return this form and any attachments to:

CHICKERING CLAIM ADMINISTRATORS, INC.
P.O Box 15708
Boston, MA 02215-0014

PART I: To be completed by student (Please Print)

SCHOOL		
STUDENT NAME	PATIENT NAME (IF DIFFERENT)	
STUDENT SOCIAL SECURITY NUMBER	STUDENT ID NUMBER	PATIENT DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER			

IS PATIENT INSURED UNDER ANY OTHER HEALTH INSURANCE PLAN? ___ YES ___ NO	(IF "YES" GIVE NAME & ADDRESS OF UNION, ASSOCIATION, OR COMPANY & POLICY NO)	IS PATIENT INSURED UNDER MEDICARE OR MEDICAID? ___ YES ___ NO
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Effective date of other coverage: _____

Parents ___ Spouse ___ Other ___ Name of Insured: _____ Subscriber ID#: _____

PLEASE SEND PAYMENT TO: PROVIDER ___ ME ___ (PLEASE ATTACH PROOF OF PAYMENT) SIGNATURE _____

COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM	COMPLETE THIS SECTION FOR A SICKNESS CLAIM
Exact nature of injury: _____ Details: _____	Date of sickness: _____ Date symptoms first noticed: _____
How: _____ When: _____ Where: _____	What is the exact nature of this sickness: _____
Was injury due to practice/play of intercollegiate or club sports? _____ Which sport? _____ <i>If sports related, please attach verification from athletic trainer.</i>	Have you ever had the same or a similar condition? _____ If yes, date of first treatment: _____ Name and Address of treating physician: _____
Is condition work related? Yes ___ No ___ Is condition due to an auto accident? Yes ___ No ___ <i>If yes, please attach auto voucher.</i>	Were you treated in the Health Service at your school for this condition? <i>(This may include Health Service, Counseling Service and Alcohol and Drug Services):</i> _____
Where were you treated in the Health Service at your school for this condition? <i>(This may include Health Service, Counseling, and Alcohol and Drug Services):</i> _____	Seen by: _____
Seen by: _____	If your claim is for services outside of the Health Service, were you referred? Yes ___ No ___
If your claim is for services outside of the Health Service, were you referred? Yes ___ No ___	
If not, why? Away from school ___ Winter/Spring Break ___ Summer ___ Weekend ___ Other _____	

If this accident or sickness has resulted in an outpatient hospital admission, have you obtained pre-certification? _____
FAILURE TO COMPLY WITH THE NOTIFICATION REQUIREMENT WILL RESULT IN A PENALTY <i>(See brochure for details)</i>

AUTHORIZATION FOR MEDICAL INFORMATION

To all Physicians, Hospitals, or other Health 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: _____
Parent, Guardian, Adult Claimant