CASE WESTERN RESERVE UNIVERSITY

NOTIFICATION OF INJURY OR ILLNESS

Return to: Wells Fargo, P.O. Box 3262, Charleston, WV 25332-3262

INSTRUCTIONS FOR THE COMPLETION OF THIS CLAIM FORM

NOTE: Only one form needs to be completed per accident or sickness regardless of the number of separate bills you receive.

1. Answer, in complete detail, questions 1-15 below. If questions are not answered completely, it may delay the processing of your claim. Date and sign form.
2. If services were rendered or ordered by a non UHS provider, please have the provider complete the Health Care Provider Section on the back of this claim form.
3. Send this claim form along with any itemized bill(s), (make sure the bills are itemized, balance forward bills or cash register receipts are not sufficient) to

   Wells Fargo, P.O. Box 3262, Charleston, WV 25332-3262.
4. **RETAIN A COPY OF EVERYTHING FOR YOUR RECORDS, (claim form, bills and receipts).**
5. All Ohio providers should send their bills: Emerald Health Network, P.O. Box 94808, Cleveland , Ohio 44101-4808.

   Providers outside of Ohio should send their bills to Wells Fargo, P.O. Box 3262, Charleston, WV 25332.
6. Wells Fargo should process your claim within 14 days after receipt. You may want to inform your creditors that you have filed the bill(s) with your medical carrier.
7. If more than 4 weeks has lapsed from the time you mailed your claim, and payment has not yet been made, call Wells Fargo toll free at 1-800-624-8605.

   A customer service representative should be able to tell you the status of your claim.
8. If you have questions about these instructions, or need assistance for any reason, contact the University Health Service at (216) 368-2450

   or stop by the University Health Service at 2145 Adelbert Road.

THIS SECTION TO BE COMPLETED BY THE STUDENT

1. Student's Name ____
2. Student's Date of Birth ______________________________________ Student's Sex: Female _____ Male ______
3. Student's Social Security Number __________ -_______ - ___________ If you do not have a Social Security Number check here _____
4. Local Address ____
5. Home Address ____
6. Did you receive care at the CWRU Student Health Service? Yes _____ No _____ Date_______________________________________
7. Were you referred for counseling or prescribed medication by a counselor at the Univ. Counseling Services? Yes _______ No ________

COMPLETE THESE QUESTIONS IF CLAIM IS FOR A DEPENDANT

8. If this is a claim for your dependant: Dependant's Name:____

9. Dependant's Date of Birth _______________________________ Dependant's Sex: Female _________ Male __________

COMPLETE THESE QUESTIONS FOR STUDENT AND DEPENDANT

10. Date injury was sustained or sickness contracted ____

11. Give a complete description of injury/sickness (where, how injury occurred/describe symptoms of illness). Use additional page if necessary.

____

____

12. If an injury, is this a recurrence of a prior injury?____

13. If an injury, was it the result of participation in intercollegiate/inter-scholastic (not intramural) sports? Yes________ No________

14. If an injury, was it the result of a motor vehicle accident? Yes _________ No __________

15. Was the injury or sickness a result of your employment? Yes _________ No __________

16. Are you enrolled in another medical insurance policy other than this one? Yes __________ No__________

I authorize any physician, insurer or other organization or person having any record, data or information concerning myself to furnish such records, data or information as may be requested by such company to WELLS FARGO or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. Any
person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

Date ____________ Signature of Student ____

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

1. Date you were first consulted ____

2. Diagnosis ____

3. Nature of symptoms or complaints ____

____

____

____

4. Length of time symptoms existed before claimant consulted you ______________________

____

____

____

5. Your recommendations for treatment ____

____

____

____

6. Dates of treatment, including medication prescribed, for this or related illness (if injury, also include date of injury)

____

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____

7. As reflected in the history, providers previously consulted by claimant

Provider's Name Dates Consulted Address, if known

______________ ____________ ______________________________

______________ ____________ ______________________________

8. Other notable illnesses or surgeries in claimant's history that may relate to this condition

____

____

9. DENTIST'S NOTE: In case of treatment of teeth, identify teeth involved and state if sound and natural

____

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Date ____________ Provider's Name (print) ______________________________ Degree ______________________

Individual Practitioners - SS # ________ - _______ - __________ (Must be furnished under authority of law)

All others - Employer ID # _______ - ____________________ (Must be furnished under authority of law)

Provider's Signature____________________________________ Telephone ______________________________

Street Address __________________________ City ________________ State ______ Zip Code ____________

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