Member Reimbursement Claim Form

School Name: Clemson University

Policy #: S211216

<table>
<thead>
<tr>
<th>Students Name</th>
<th>School ID Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male □ Female □</td>
</tr>
</tbody>
</table>

Mailing Address where Insurance Info/Request should be mailed City, State, Zip

Please indicate a phone number where you can be reached: ( )

Claim Filing Instructions

- We need an itemized bill to process the claim correctly. We can’t accept receipts, balance due statements and cancelled checks in place of the itemized bill.

- Itemized bills must include:
  - Patient Name
  - Date of Service
  - Diagnosis code (ICD format)
  - Type of service/procedure code
  - Charge for the service(s)
  - Healthcare Professional Tax ID number
  - Healthcare Professional name/credentials
  - Healthcare Professional address

- We suggest you make a copy of your bill(s) and your completed claims form for your records

- Prescription receipts which include the drug name, dosage, quantity and charge are acceptable for reimbursement.

Mailing Instructions

- Send your completed claim form and itemized bills to the following address:

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

- If you have additional questions, please contact Customer Service at 877-657-5030.

Signature of claimant or legal guardian ___________________________ Date ___________________________