Ascension Benefits & Insurance Solutions
PO BOX 25936
Overland Park, KS 66225
1-877-246-6997

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING - SEE BACK FOR FILING INSTRUCTIONS.

TO BE COMPLETED BY PARENT/STUDENT

NAME OF PATIENT (Last Name) (First Name) (Middle Initial) | STUDENT ID NUMBER

ADDRESS (Street) (City) (State) (Zip)

PHONE NUMBER | DATE OF BIRTH | MALE ❑ FEMALE ❑

DATE & TIME ACCIDENT OR ILLNESS BEGAN | WAS ACCIDENT DUE TO EMPLOYMENT? YES ❑ NO ❑

NATURE OF INJURY OR ILLNESS | HAVE YOU EVER BEEN TREATED FOR THIS CONDITION BEFORE? YES ❑ NO ❑

IF ACCIDENT, PLEASE STATE HOW, WHEN, AND WHERE ACCIDENT OCCURRED: _____

IS INJURY RELATED TO PARTICIPATION IN INTERCOLLEGIATE SPORTS? YES ❑ NO ❑

DO YOU HAVE ANY OTHER INSURANCE, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL HEALTH AND/OR ACCIDENT, GOVERNMENT PLAN, OR AUTOMOBILE PLAN? YES ❑ NO ❑

IF YES, PLEASE GIVE NAME, ADDRESS, PHONE NUMBER, AND POLICY NUMBER OF THIS PLAN. _____

SUBSCRIBERS NAME: _____ EFFECTIVE DATE: _____

IF UNDER THE AGE OF 18, PLEASE PROVIDE PARENT/GUARDIAN'S INFORMATION BELOW:
NAME OF PARENT/GUARDIAN (Last Name) (First Name) (Middle Initial)

ADDRESS (Street) (City) (State) (Zip)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.

Signature _____ Date _____

AUTHORIZATION TO PAY PROVIDER

I authorize payment of charges associated with this incident directly to the physicians or providers. I further certify that the foregoing information is true and correct.

Signature _____ Date _____

TO BE COMPLETED BY THE SCHOOL

NAME OF SCHOOL/ORGANIZATION | POLICY NUMBER

ADDRESS OF SCHOOL | TELEPHONE NUMBER OF SCHOOL/ORGANIZATION

WAS REFERAL GIVEN TO STUDENT? YES ❑ NO ❑

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE | TITLE