## **CLAIM FORM**

## AETNA LIFE INSURANCE COMPANY

Non-completion of this form may result in delay or denial. If other insurance exists, attach payment or denial.

Please return this form and any attachments to:

## CHICKERING CLAIMS ADMINSTRATORS, INC. P.O Box 15708

Boston, MA 02215-0014

PART 1: To be completed by student (Please Print)								
SCHOOL								
STUDENT NAME	PATIENT	T NAME (IF DIFFERENT)						
STUDENT SOCIAL SECURITY N	NUMBER STUDEN	T ID NUMBER	PATIENT DATE OF BIRTH					
ADDRESS	CITY		STATE ZIP CODE					
TELEPHONE NUMBER								
IS PATIENT INSURED UNDER ANY OTHER HEALTH INSURA		UNION, ASSOCIATION, OR COMPANY & POLICY NO)	I S PATIENT INSURED UNDER MEDICARE OR MEDICAID?					
Yes No			$\square$ Yes $\square$ No					
Effective date of other cover	rage:							
Parents  Spous	e Other Name o	of Insured: Subscr	iber ID#:					
PLEASE SEND PAYMEN		E ATTACH PROOF OF PAYMENT) <b>SIGNATU</b>						
COMPLETE THIS S	ECTION FOR AN ACCIDENT CLAIM	COMPLETE THIS SECTION FOR A SICKNESS CLAIM						
Details:  How: When: Where:  Was injury due to practice / play Which sport?  If sports related, pla Is condition work related? Is condition due to an accident? If yes, please attach auto vouche Where were you treated in the H May include Health Service, Con Seen by:	ealth Service at your school for this condition? (This unseling, and Alcohol and Drug Services):  de of the Health Service were you referred?  Yes No	Date of sickness:  Date symptoms first noticed:  What is the exact nature of this sickness:  Have you ever had the same or similar condition?  If yes, date of first treatment:  Date of last treatment:  Name and address of treating physician:  Were you treated in the Health Service at your school for this condition? (This m include Health Service, Counseling Service and Alcohol and Drug Services)  Seen by:  If your claim is for services outside of the Health Service, were you referred?  Yes No   Weekend   No   Weekend   W						
If this accident or sickn	ess has resulted in an outpatient hospit	al admission, have you obtained pre-ce	rtification?					
FAILURE TO COMPI	Y WITH NOTIFICATION REQUIRE	EMENT WILL RESULT IN A PENAL	<b>FV</b> (See brochure for details)					

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		

## PART 2: To be completed by attending physician ATTENDING PHYSICIAN'S STATEMENT

1.	Nature of sickness or injury.  Describe any complications.										
2.	If fracture or dislocation, state whether reduced or immobilized. If fracture of long bones, state whether fracture is through shaft or extremity. Was it										
3.	confirmed by X-ray?  When did symptoms first appear or	□ No	Yes								
4.	accident happen? When did patient first consult you for	Date									
5.	this condition?  Has patient ever had same or similar	Date									
	condition? If yes, state when and describe.	□ No	Yes	When? I	Date		Describe:				
6.	Describe any other disease or infirmity affecting present condition.										
7.	Nature of any surgical or obsterical Procedure. Describe fully, include CPT code. Where and when performed?	Date			_ If in hospita	l, inpatient	outpati	ent 🗆			
8.	Give dates of treatment.										
9.	Is condition a result of or in any way connected with pregnancy?	□ <sub>No</sub>	□ Yes	Inceptio	n date of pregn	nancy					
10.	Is patient still under your care for this condition? If discharged, indicate when.	☐ No	Yes	When?	Date						
11.	If patient hospitalized, give name and address of hospital.										
	Hospital Date admitted		Date disch	arged		City		State		_	
12.	Did you file this claim with any other Insurance Company? If yes, indicate name and address of company.	□ <sub>No</sub>	□ <sub>Yes</sub>		:						
			PAF	RT 3: To l	be completed l	oy provider					
(Pleas	se Print)										
	E										
	ED: r S.S. #		MUST BE II	DEGRE NCLUDED	E D) PHONE#				DATE		
ADD	RESS: Street		City				State			Zi	p
PATI	ENT'S NAME		DOES PA	TIENT HA	VE OTHER (	COVERAGE?		IF YES, PL	EASE IDEI	NTIFY	
	IS CONDITION DUE TO INJURY OR SICKNESS GIVE DETAILS:  ARISING OUT OF PATIENT'S EMPLOYMENT? NO YES					PREGNAN YES	CY?		MATE DATE	CED:	
	GNOSIS AND CONCURRENT CONDITION								IAD SAME	OR SIMLIAR C	ONDITION?
REPO	ORT OF SERVICES (IF PREVIOS FORM S	UBMITTED	, YOU NEE	D ONLY	DATES AND	SERVICES SI	INCE LAST	REPROT) O	R ATTACH	H ITEMIZED BIL	L
DATI SERV	E OF PLACE OF VICES SERVICES		ΓΙΟΝ OF SU SERVICES			PROCEDU	JRE CODE U	<u>ISED</u>		<u>CHARGES</u>	
							TOTAL CH	HARGES		\$	
	E SYMPTOMS FIRST APPEARED CCIDENT HAPPENED		ΓΙΕΝΤ FIRS THIS CONI		ILTED		AMOUNT	PAID		\$	
IS PA	TIENT STILL UNDER YOUR CARE FOR	THIS CON	DITION?				BALANCE	DUE		\$	