

Rutgers – The State University – Student Insurance Claim Reporting Form
The MEGA Life and Health Insurance Company (Policy # 2006-519-1)

Submit claim form and itemized bills to:

Rutgers University
Office of STUDENT INSURANCE
Hurtado Health Center, 11 Bishop Place
New Brunswick, NJ 08901-1180

Undergraduate Student Graduate Student International Student Male Female

Student Name: _____ SS# _____ DOB _____

Last Name

First Name

Date of Birth

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

E-mail Address: _____

If claim is for a dependent, give name and relationship _____

Claim Information:

Reason for Medical Treatment /Describe Sickness/Injury: _____

If injury, indicate date and describe how and where accident occurred: _____

Was the Injury/Sickness caused by: Patient's Employment Intercollegiate Sports Intramural Sports (attach team roster)

Other _____

Were you treated by Rutgers University Health Services? Yes If yes, date of treatment _____ No

If referred by RUHS - attach copy of referral

Medical History:

Date you first were seen for this condition: _____

Name of Doctor who first treated you for this condition: _____

Address: _____ Phone _____

Note: The Student Insurance is an EXCESS Policy over all other available insurance. All bills must be filed with your primary carrier first. Unpaid balances can be submitted to the student policy with a copy of the primary insurance Explanation of Benefits.

Other Insurance Information:

Will any other insurance pay for any of the medical expenses of this claim? Yes No

Type of Coverage: Individual Through employer Auto Insurance

Name of Policyholder (parent / self / spouse) _____

Employer's Name (if applicable): _____

Insurance Company Name _____

Address _____

Policy Number: _____

PAYMENT WILL BE MADE TO THE PROVIDER OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE CLAIM AT TIME OF SUBMISSION.

I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding my medical history, treatment, or benefits for this claim, to the insurance company or its representative. A photo static copy of this authorization shall be considered as effective and valid as the original.

Student Signature _____ Date _____

Student's signature, if age 18 (otherwise Guardian)

Spouse Signature _____ Date _____

If claim is for spouse, (s)he should also sign here

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

Fraud Warning: Any person who knowingly files a statement or claim containing any false or misleading information is subject to criminal or civil penalties.