Name of Student _____ Student ID# _____ Date of Birth _____

Current Address _____
Number and Street City State Zip Code Phone Number

Name of Insured Dependent _____ Date of Birth _____
if applicable

Current Address _____
Number and Street City State Zip Code

HEALTH CENTER REFERRAL: ❑ No ❑ Yes **IF YES, REFERRAL MUST BE ATTACHED**

REFERRAL ISSUED BY: _____ DATE: _____

CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED

1. Date of injury or beginning of sickness: _____ When was physician first consulted? _____
2. Nature of injury or sickness: _____
3. If injury, describe how and where accident occurred: _____
4. Did injury occur during practice or play of sports? ❑ No ❑ Yes
   If yes, please check one of the following: ❑ Intramural/Club Name of Sport _____
   ❑ Intercollegiate Signature of Athletic Trainer _____
   ❑ Other _____
5. Have you suffered same or similar condition before? ❑ No ❑ Yes
   If yes, and you were previously treated for it, dates treated: _____
   Name and address of physician who treated you: _____
6. If hospitalized at that time, date confined to hospital: _____
   Name and address of hospital: _____
7. Was the injury the result of a motor vehicle accident? ❑ No ❑ Yes

Do you have other insurance that covers your condition (group, individual, automobile, medical, or liability)? ❑ No ❑ Yes

If yes, who is the Holder of Policy: ❑ Self ❑ Parent ❑ Spouse Name of Insurance Company: _____

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy No. _____ Group No. _____ Phone No. of Insurance Co. _____

Parent's/Spouse's Name (Holder of Policy) _____ S.S. No. _____

Employer's Name and Address _____

Have you been insured under another health insurance plan any time during the past 12-month period? ❑ No ❑ Yes

If yes, give name of company and attach a copy of your Certificate of Prior Coverage: _____

Address: _____ Phone Number: _____

Policy Number: _____ Effective Date of Coverage: _____ Date Coverage Terminated: _____

ASSIGNMENT OF BENEFITS

CLAIMANT (OR PARENT, IF MINOR) MUST COMPLETE IN FULL INDICATING TO WHOM PAYMENT IS TO BE MADE. (PLEASE PRINT.)

Dr.:	Hosp:	Other:
_____	_____	_____
Address	Address	Address
_____	_____	_____
City State	City State	City State

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

AUTHORIZATION: I hereby authorize Personal Insurance Administrators, Inc., or its representative to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, X-rays, and any other data covering this and/or previous confinements and/or disabilities.
A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize Personal Insurance Administrators, Inc., to pay bills in connection with this claim directly to the Doctor, Hospital, or Other Payee indicated above. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

SIGNATURE OF STUDENT _____ **DATE** _____

SEE PAGE 2 FOR INSTRUCTIONS ON FILING A CLAIM

CLAIM PROCEDURE

Please read the following information on accessing benefits and filing claims.

1. Except as otherwise noted in the Summary Description of Benefits, you must visit the PUC Health Clinic first for a referral before seeking treatment elsewhere. If a referral is required but not obtained, the plan will NOT pay for your treatment and you will be responsible for all charges.
2. Except in the case of an emergency, if you obtain treatment by a provider or facility that is not part of the EPO, the plan will NOT pay for your treatment and you will be responsible for all charges.
3. In the case of an emergency, you must contact the PUC Health Clinic within 24 hours from the date of receiving emergency medical care services and/or being discharged from a hospital emergency room or facility. You may also be required to return to the PUC Health Clinic for necessary follow-up care within 72 hours from the date of receiving emergency medical care services and/or being discharged from a hospital emergency room or facility.
4. As indicated in the Summary Description of Benefits, certain Eligible Health Care Services and prescription drugs covered under the plan require prior authorization in order for benefits to be payable. If prior authorization is required but not obtained, benefits may NOT be payable for those services under the plan. Contact American Health Holdings at **(888) 638-5706** to obtain authorization **prior to** receiving treatment, or Express Scripts at **(800) 889-0376** to obtain authorization **prior to** filling a prescription. See the Summary Description of Benefits for specific requirements and time frames.
5. After you receive treatment, you will be charged the deductible first before the company will begin paying benefits (except as otherwise noted).
6. After you receive treatment at an EPO provider, the provider may submit the charges directly to the claims administrator for you. In this case, you will receive an Explanation of Benefits indicating what the plan covered, and then the provider will bill you for any remaining charges. If the provider does not submit the charges directly, YOU will be responsible for filing a claim. In this case, you must complete the claim form and, within 90 days of treatment, send it along with any itemized hospital and medical bills to:

   Personal Insurance Administrators, Inc.
   P.O. Box 6040
   Agoura Hills, CA 91376-6040
7. If you have questions about the status of your claim after it has been submitted or for any questions about benefits, please call Personal Insurance Administrators, Inc., at **(800) 468-4343**, Monday–Friday from 8:00 a.m. to 5:00 p.m. (4:00 p.m. on Fridays) PT. ***Always keep a copy of all documents submitted for claims.***

How to File a Claim Under the Plan

Ordinarily, when you seek medical care, the Plan's EPO provider will submit a claim for coverage on your behalf. However, it is your responsibility in all cases to make sure that your claim for coverage of any medical care, service, supply or medication is filed with the Plan Administrator. The Plan Administrator can provide you with a copy of the appropriate form for making claims under the Plan. The Plan Administrator may appoint a Claims Administrator under the Plan. If no Claims Administrator is appointed, the Plan Administrator will be the Claims Administrator.

For the purposes of the Plan, Personal Insurance Administrators, Inc. (PIA), shall be the Claims Administrator as appointed by PUC.

Time Limit: You must file a completed Claim for benefits as to any Eligible Expense not later than 90 days or the expense will not be covered under the Plan.

A Completed Claim means a claim for benefits as to an Eligible Expense on a form satisfactory to the Claims Administrator, accompanied by proof of payment and the provider's description of services received, supplies or medications as appropriate, plus any additional documentation requested by the Plan Administrator to substantiate that coverage is appropriate under the Plan.

Authorized Representative

An authorized representative may act on your behalf with respect to a benefit claim or appeal under these claims procedures. You must submit a signed Plan-approved form designating your authorized representative before the Plan will recognize your authorized representative.

However, the Plan will recognize a health care professional with knowledge of your medical condition as your authorized representative if your claim is for urgent care.

An authorized representative form may be obtained from and completed forms must be submitted to:

Personal Insurance Administrators, Inc. (PIA)
P.O. Box 6040
Agoura Hills, CA 91376-6040
Phone: (800) 468-4343
Fax: (818) 735-3567
Email: info@pia-inc.com

Once an authorized representative is appointed, the Plan will direct all information, notification, etc. regarding the claim to the authorized representative. You will be copied on all correspondence.

You are entitled to full and fair review of any claim for benefits made under the Plan. Please see the Summary Description of Benefits for a full description of how benefit claims and appeals are made and decided.