

# CLAIM FORM

Please return this form and any attachments to:  
**CHICKERING CLAIMS ADMINISTRATORS, INC.**  
P.O. Box 15708  
Boston, MA 02215-0014

## Aetna Insurance Company of Connecticut

Non-completion of this form may result in delay or denial.

**Part 1: To be completed by student (Please Print)**

<b>NEW YORK UNIVERSITY</b>	
<b>STUDENT NAME</b>	<b>PATIENT NAME (IF DIFFERENT)</b>

<b>STUDENT SOCIAL SECURITY NUMBER</b>	<b>PATIENT DATE OF BIRTH</b> / /
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<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
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<b>TELEPHONE NUMBER</b>
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IS PATIENT INSURED UNDER ANY OTHER INSURANCE PLAN <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, GIVE NAME AND ADDRESS OF COMPANY & POLICY NO.	IS PATIENT INSURED BY MEDICARE OR MEDICAID? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Effective date of other coverage: \_\_\_\_\_  
Parents  Spouse  Other  Name of Insured: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

**PLEASE SEND PAYMENT TO THE PROVIDER  ME  (PLEASE ATTACH PROOF OF PAYMENT)**

**SIGNATURE** \_\_\_\_\_

<b>COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM</b>	<b>COMPLETE THIS SECTION FOR A SICKNESS CLAIM</b>
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Exact nature of injury: \_\_\_\_\_  
Details: \_\_\_\_\_  
How: \_\_\_\_\_  
When: \_\_\_\_\_  
Where: \_\_\_\_\_

Was injury due to practice or play of intercollegiate or club sports? \_\_\_\_\_  
Which sport? \_\_\_\_\_  
If sports related, please attach verification from athletic trainer.

Is condition work related?  Yes  No  
Is condition due to an auto accident?  Yes  No  
If yes, please attach auto voucher.

Were you treated in the UHC for this condition? \_\_\_\_\_  
If your claim is for services outside of the UHC 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 UHC for this condition? \_\_\_\_\_  
If your claim is for services outside of the UHC were you referred?  Yes  No

If not, why?  Away from school  Winter Break  Other

<b>If this accident or sickness has resulted in an inpatient hospital admission, have you obtained pre-certification?</b>
<b>FAILURE TO COMPLY WITH NOTIFICATION REQUIREMENT WILL RESULT IN A PENALTY (See brochure for details)</b>

### AUTHORIZATION FOR MEDICAL INFORMATION

**To all Physicians, Hospitals and 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, advise, 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