TRAVEL GUARD CHARTIS

HSR Health Special Risk, Inc.

Wells Fargo Study Abroad Inbound/Outbound Insurance Program

1. Please fully complete this form
2. Attach itemized bills
3. Mail to: *Health Special Risk, Inc.*

Email: WFstudyabroad@hsri.com

HSR Plaza
4100 Medical Parkway
Carrollton, Texas 75007
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free1-866-523-3183

Travel Assistance and Medical Emergency
US or Canada Toll Free
(877) 244-6871
Outside US or Canada Call Collect

TO BE COMPLETED BY STUDENT

School Name: _____ Policy #_____

1. Student Name _____ Student ID Number _____-_____-_____ Date of Birth_____-_____-_____

2. Mailing Address _____
Number Street City State Zip

3. Permanent Address _____
Number Street City State Zip

4. Best Contact Phone Number, Including Area Code (_____) _____ Email: _____

5. Gender ☐ Male ☐ Female 6. Patient Status ☐ Single ☐ Married

7. Is this claim for a dependent? ☐ Yes ☐ No If yes, give name _____

Relationship_____ Date of Birth _____-_____-_____

8. Describe the conditions that caused this claim: (Select one and attach additional pages if needed): ☐ Illness ☐ Injury ☐ Death

_____Date of Initial Treatment _____-_____-_____

9. Has the patient been treated for the above condition(s) in the last 6 months? ☐ Yes ☐ No

If yes, give condition(s) treated for and date(s) of treatment_____

10. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident _____-_____-_____

Where did the accident occur? _____

How did the accident happen? _____

What country did the accident occur in? _____

11. Is this claim the result of a work related injury? ☐ Yes ☐ No

12. Is the patient covered for benefits (other than this policy) by any of the following?

☐ Yes ☐ No Any individual, Blanket or Short Term Medical Insurance?

☐ Yes ☐ No Group Health Benefits of an kind through an employer, spouse's employer or parent's employer?

☐ Yes ☐ No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

If any of the above apply, please complete the following:

Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____
Name Relationship

Insurance Co. or Benefit Plan _____ Sponsor or Employer _____

Insurance Co. Address _____ Sponsor Address _____

Telephone (_____) _____ Plan/Group Number _____ Sponsor Telephone (_____)_____

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

☐ Issue reimbursement directly to Participating Organization _____

☐ Issue reimbursement directly to Insured (please submit proof of payment)

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

MultiPlan

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for and the specific itemized charges incurred.
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (800) 328-1114. They are available from 7:00 a.m. thru 7:00 p.m., Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007