Member Reimbursement Claim Form

School Name: University of South Carolina

Policy #: S211916

Students Name | School ID Number | Date of Birth
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Mailing Address where Insurance Info/Request should be mailed | City, State, Zip

Please indicate a phone number where you can be reached: ( )

Claim Filing Instructions

- We need an itemized bill to process the claim correctly. We can’t accept receipts, balance due statements and cancelled checks in place of the itemized bill.

- Itemized bills must include:
  - Patient Name
  - Diagnosis code (ICD format)
  - Date of Service
  - Type of service/procedure code
  - Charge for the service(s)
  - Healthcare Professional Tax ID number
  - Healthcare Professional name/credentials
  - Healthcare Professional address

- We suggest you make a copy of your bill(s) and your completed claims form for your records

- Prescription receipts which include the drug name, dosage, quantity and charge are acceptable for reimbursement.

Mailing Instructions

- Send your completed claim form and itemized bills to the following address:

  Consolidated Health Plans
  2077 Roosevelt Avenue
  Springfield, MA 01104
  Fax (413) 733-4612

- If you have additional questions, please contact Customer Service at 877-657-5030.

Signature of claimant or legal guardian ___________________________ Date ___________________