Member Reimbursement Claim Form

School Name: University of South Carolina Policy #: ST0041SH

Students Name	School ID Number	Date of Birth Male □ Female □
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 — Date of Service
  Diagnosis code (ICD format) — 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.
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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 _____