STATE UNIVERSITY OF NEW YORK INTERNATIONAL STUDENT/SCHOLAR
HEALTH CENTER AUTHORIZATION & REFERRAL CLAIM FORM – FOR CLAIMS IN THE U.S.

HEALTH CENTER AUTHORIZATION
Health Center Use Only

Authorization Stamp (or SHC Reps Initials) _____

Date of Service/Referral _____

HTH Worldwide
PO Box 30259
Tampa, FL 33630
Telephone: 1.888.350.2002 Fax: 1.888.250.4121

Send completed form and any supporting documentation (medical bills, receipts and/or statements, pharmacy receipts) to the above address. See the back of this form for more information regarding information on how to file a claim. ***Claims reimbursement is subject to a $100 deductible for each medical condition. If the student FIRST seeks medical treatment at the campus Student Health Center, the deductible will be waived (participants on OPT/CPT have a $50 deductible which can not be waived). The Health Center must stamp the top of this form for the waiver to be approved, and this form must be submitted to the above address. Dependents are subject to a $50 deductible per condition, which cannot be waived. Dependents cannot be seen at the Student Health Center.***

PLEASE TYPE OR PRINT • USE A SEPARATE FORM FOR EACH PATIENT

PATIENT INFORMATION			PRIMARY POLICY HOLDER INFORMATION (on ID Card)		
NAME Last First Middle			CERTIFICATE NUMBER	GROUP NAME **SUNY**	COLLEGE/ UNIVERSITY NAME
BIRTH DATE	SEX M F	RELATION TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Son ☐ Daughter	NAME Last First Middle		
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO			ADDRESS		
NAME OF OTHER HEALTH INSURANCE COMPANY			CITY	STATE	ZIP CODE
POLICY NUMBER of PRIMARY POLICY HOLDER			HOME PHONE NO. ( ) area code	COLLEGE ID NUMBER	

MEDICAL REFERRAL INFORMATION

Please list the name and address of the doctor or facility to which you are be referred to and briefly describe the medical problem (illness/injury) and area of body affected :

_____

INJURY QUESTIONNAIRE

If the condition related to this referral is a result of an accident/injury, please complete the following section

Date of accident or beginning of condition: _____
Month Day Year

Describe exactly how the accident took place: _____

_____

_____

Please indicate if the injury was related to any of the following:

☐ School related Injury ☐ Sports related injury ☐ Work related accident or illness ☐ Automobile/Motorcycle accident
☐ intercollegiate sport
☐ intramural sport

If the condition is a work related accident or a auto/motorcycle accident, please provide the following information:

Name of Employer:
(For work related accident) _____

Name of Insurance Carrier:
(For auto/motorcycle accident) _____ Policy #: _____

Address: _____

Phone Number: _____ Contact: _____

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. This claim will be returned if this claim form is not signed.
Applicants applying for accident and health insurance in New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

x _____ _____
Signature of Insured Member Date

INSTRUCTIONS FOR THE USE OF THIS FORM

Dear SUNY Member:

In order to have the Injury and Sickness Deductible waived, you must have authorization from the campus Student Health Center for outside care, and it must be sent to HTH Worldwide. The completion of this form, with proper authorization and its timely filing with HTH Worldwide, will ensure your claim is adjudicated properly. If this form is not completed and mailed to HTH Worldwide immediately, HTH Worldwide will not know you were referred at the Student Health Center and a deductible may apply.

If a hospital, physician, ambulance company or other provider send their bill directly to you, HTH Worldwide has no way of knowing about your claim until the bill is received at HTH Worldwide. This form was developed for you to notify HTH Worldwide of any covered health services for which we have not already been billed directly and to provide us with additional information that may be needed in order to process your claim.

Please read the following instructions about how to report health care services. We are happy to serve you.

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THE SERVICE TYPES LISTED BELOW

REGISTERED AND LICENSED VOCATIONAL NURSING SERVICES
- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT
- Doctor's orders or prescriptions
- Purchase price

OUTPATIENT PRESCRIPTION DRUGS
- Duplicate pharmacy generated receipt (not register tape)
- Must include prescribing doctor's name, name of medication, date filled and amount charged, Rx number; date filled; form, strength & quantity dispensed

AMBULANCE
- Pick-up and delivery points
- Number of miles

ANESTHESIA
- Start Time
- End Time
- Surgical procedure
- Surgeon Name and address

PHYSICAL THERAPY
- Medical Records
- Prescription from referring physician indicating the number of visits prescribed

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BILLS MUST BE ITEMIZED

Canceled check, cash register receipts and non-itemized "balance due" statements cannot be processed. If the bill is from a Hospital, Form UB-92 should be submitted. If being billed from a doctor a HCFA-1500 is preferable. Each itemized bill must include:
- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Provider taxpayer I. D. number
- Name of patient
- Date(s) of service
- Amount charged for each service
- Total Charge
- Diagnosis Code or reason for treatment
- Procedure Code(s) description of services performed

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Physicians/Providers:
For electronic filing Payor ID: 60054

Reminder: ***This form is only to be used if treatment that was received in the United States.***