Mail form to:
Northern Illinois University
Student Insurance Office
Health Services, Room #201
DeKalb, IL 60115

NIU Student Health Insurance

Claim Form

Phone: 815-753-0122
Fax: 815-753-0965
www.studentinsurance.niu.edu
StudentInsurance@niu.edu

UNICARE LIFE AND HEALTH INSURANCE COMPANY OF THE MIDWEST

HCH Administration / Academic Health Plans

This form must be fully completed, signed by the claimant and returned to this office within 12 months from the date of service, or claim processing may be delayed or denied.

School: Northern Illinois University   Policy #141251   Claim Info: 866-679-0831

STUDENT LAST NAME	FIRST	PATIENT NAME (IF DIFFERENT)	Z-ID#
LOCAL ADDRESS		PHONE NUMBER	PATIENT DATE OF BIRTH
CITY	STATE	ZIP	

IMPORTANT - COMPLETE THIS SECTION!!

DO YOU HAVE ANY OTHER HEALTH INSURANCE, EITHER GROUP OF INDIVIDUAL? ❑ YES ❑ NO

DOES EITHER OF YOUR PARENTS COVER YOU ON THEIR POLICY? ❑ YES ❑ NO

IF YES,
WHAT IS THE NAME OF INSURANCE COMPANY? ____________ WHAT IS THE POLICY #? ____________

WHEN DID THIS INSURANCE START? END DATE?

Payment will be made to the provider unless a receipt is submitted with the claim.

COMPLETE THIS SECTION FOR ACCIDENT OR INJURY CLAIM	
Date & time of accident or injury:	
What is the exact nature of your injury:	
If the injury is due to play or practice of an NIU sports, which one was it?	
Was the accident/injury work related? ❑ YES ❑ NO	
Was the accident/injury due to an auto accident? If yes, attach the accident report. Please provide a copy of any police report that was filed. ❑ YES ❑ NO	
Is any other insurance responsible for payment of this accident/injury? (This would include auto, home owner or business insurance and worker's compensation) ❑ YES ❑ NO	
Is there any possible, pending, or resolved legal action regarding this matter? YES ❑ NO	

OR

COMPLETE THIS SECTION FOR ILLNESSES	
Date symptoms first noticed:	
What is the exact nature of the illness?	

OR

COMPLETE THIS SECTION FOR OTHER CLAIMS	
Date of Doctor's visit:	
What is the reason for the office visit?	

AUTHORIZATION FOR MEDICAL INFORMATION

TO ALL PHYSICIANS, HOSPITALS, NIU HEALTH SERVICES AND OTHER PROFESSIONALS: YOU ARE AUTHORIZED TO PROVIDE UNICARE HEALTH INSURANCE COMPANY OF THE MIDWEST AND/OR HCH ADMINISTRATION, AND ANY INDEPENDENT CONSULTING HEALTH PROFESSIONAL OR AUDITOR ACTING ON ITS BEHALF OR THAT OF THE INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE, ADVICE, 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 (if 18 years or older – parent/guardian if younger)   Date

4/27/09