



P.O. Box 6947  
Boise, ID 83707-0947  
Phone 1-888-955-1561

Nationwide Life Insurance Company  
**Lewis-Clark State College**

*Health Benefit Claim Form*

**Insured Student**

<b>1. Student's Name</b>	<b>2. Date of Birth</b>	<b>3. Student's Address</b>
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**4. Complete if Accident/Injury:** (Use the back of this page if additional room is needed.)

Original date of injury: \_\_\_\_\_

Where did the injury occur? \_\_\_\_\_

Details of injury: \_\_\_\_\_

\_\_\_\_\_

MVA related? Yes or No      If yes, a separate Lien Agreement letter will be mailed to you to complete and sign.

**5. Complete if Sickness**

When did symptoms begin? \_\_\_\_\_

Type of sickness: \_\_\_\_\_

Date patient first sought treatment: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Have you had this condition before? \_\_\_\_\_

If yes show dates of prior treatment: \_\_\_\_\_

**6. Is there other Medical  Dental  Coverage (other than listed above)?**  
 No     Yes (If yes, please provide the following information.)

Name of insurance company: \_\_\_\_\_ Policyholder name: \_\_\_\_\_

Effective date of policy: \_\_\_\_\_ Termination date of policy: \_\_\_\_\_

If student is the policy holder is the other health plan: \_\_\_\_\_ Group Health    \_\_\_\_\_ Individual Plan

**7. Student Health Center Referral**      To be completed by Health Center authorized personnel Only

Date seen at Student Health Center \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Referred to: \_\_\_\_\_

Authorized Signature \_\_\_\_\_

**Important: This form must be completed and returned to the company within 90 days from the date of treatment accompanied by all bills incurred to that date. Please attach itemized bills**

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**AUTHORIZATION:** I hereby authorize Nationwide Life Insurance Company/AmeriBen, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize Nationwide Life Insurance Company/AmeriBen to pay bills in connection with this claim directly to the Doctor, Hospital or Other Payee indicated above. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

**SIGNATURE OF STUDENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_