

**University of Washington  
Student Accident and Sickness Insurance Plan**

Underwritten by LifeWise Assurance Company



**Instructions:**

Complete this form, attach all itemized bills, and send to the Claims Office. Be sure to keep a copy for your records.

**PART I - TYPE(S) OF CLAIM:** Check type(s):     Medical     Dental     Vision

**PART II - STUDENT DATA:**

UW Student ID #: \_\_\_\_\_

Student Name: \_\_\_\_\_  
(First Name)                      (Last Name)                      (MI)

Social Security No.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street)    (City)    (State)    (Zip)

Spouse Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**PART III - PATIENT DATA:**

Claim is for:     Self     Spouse     Dependent Child     Domestic Partner

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First Name)                      (Last Name)

**PART IV - OTHER INSURANCE INFORMATION:**

Does patient have other health insurance coverage:     Yes     No    If yes, type of coverage:     Medical     Dental     Vision

Subscriber Name: \_\_\_\_\_ Subscriber Soc. Sec. No.: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Insurance company/plan administrator's name, address, telephone, policy/plan number: \_\_\_\_\_

**PART V - CLAIM INFORMATION (complete only applicable information):**

Are expenses related to an injury?     Yes     No    If yes, indicate date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_ and type of injury:

Automobile     Home/Recreational     Intercollegiate sport

Employment-Related: Name, address & telephone of employer: \_\_\_\_\_

Other \_\_\_\_\_

Briefly describe injury: \_\_\_\_\_

**Note: If claim is related to an injury, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.**

**PART VI - AUTHORIZATION TO PROCESS CLAIM:**

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. **It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.**

I authorize benefit payment to the health provider for the services and/or supplies described on this claim form.     Yes     No

Is claim for reimbursement of expenses paid by you? If so, benefits for covered expenses will be made payable to you.     Yes     No

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Parent Signature (if minor)    Date

## CLAIM FILING TIPS

WE WANT YOUR CLAIMS TO BE PAID ACCURATELY AND TIMELY.  
USING THE FOLLOWING TIPS WILL HELP US PROVIDE YOU WITH BETTER SERVICE.

### DOs

- Answer all questions and sign the 'Claim Form'.
- Submit the Claim Form with an itemized billing statement, which includes:
  1. Student name
  2. Patient name
  3. Provider name & Provider Tax ID number
  4. Date(s) of service
  5. Diagnosis (preferably with code number)
  6. Types of service (preferably with code number)
  7. Billing charges for each type of service rendered
- Try to batch your claim submissions (send several itemized bills at one time). This helps to keep costs down.
- **If you have other insurance coverage**, please remember to submit your claim(s) to the other **insurance plan *first***. (Refer to the Accident and Sickness Insurance Plan brochure, 'Excess Provision'). When you receive the "Explanation of Benefits" statement from the other insurance plan showing the total amount paid, then you should submit the claim to WPAS with a copy of the billing from your provider and a copy of the other plan's EOB (Explanation of Benefits) statement.

**Exception:** The Claims Office will internally coordinate the processing of a claim, if both plans are administered by WPAS.

Mail Claims to:

**UW/WPAS Claims Office  
PO Box 34600  
Seattle, WA 98124-1600**

Fax Claims to:

**(206) 441-9110**

For Questions, call:

**Toll-Free 1 (866) 535-8503  
or Local (206) 374-9439**

### DON'Ts

- Never send a "balance forward bill" to the Claims Office.
- Make certain you know who is going to file your claim. Do not submit a claim yourself if your health care provider tells you they will submit the claim on your behalf. Duplicate claim filings add to the administrative expenses of operating the plan.