



Wells Fargo Study Abroad Insurance Program

HSR Plaza
4100 Medical Parkway
Carrollton, Texas 75007
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free 1-866-523-3183

Email: WFstudyabroad@hsri.com

TO BE COMPLETED BY STUDENT

School Name: _____ Policy # _____

1. Student Name _____ Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____

2. Mailing Address _____ Number _____ Street _____ City _____ State _____ Zip _____

3. Permanent Address _____ Number _____ Street _____ City _____ State _____ Zip _____

4. Local Phone (_____) _____ Home Phone (_____) _____ Email: _____

5. Patient Status Male Female Single Married

6. Is this claim for a dependent? Yes No If yes, give name _____

Relationship _____ Date of Birth _____ - _____ - _____

7. Name of Physician _____ Date of Initial Service _____ - _____ - _____

8. Description of illness or injury _____

9. Has the patient been treated for the above condition(s) in the last 6 months? Yes No

If yes, give condition(s) treated for and date(s) of treatment _____

10. Is this claim the result of an accident? Yes No If yes, give date of accident _____ - _____ - _____

Where did the accident occur? _____

How did the accident happen? _____

11. Is this claim the result of a work related injury? Yes No

12. Is this claim the result of intercollegiate sports? Yes No

13. Is the patient covered for benefits (other than this policy) by any of the following?

Yes No Any individual, Blanket or Short Term Medical Insurance?

Yes No Group Health Benefits of an kind through an employer, spouse's employer or parent's employer?

Yes No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

If any of the above apply, please complete the following:

Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____

Insurance Co. or Benefit Plan _____ Sponsor or Employer _____

Insurance Co. Address _____ Sponsor Address _____

Telephone (_____) _____ Plan/Group Number _____ Sponsor Telephone (_____) _____

If Blue Cross, show Group and Certificate No. from Blue Cross ID card _____

14. Is patient covered under MEDICARE? (please mark all that apply): Part A Part B Not Covered

If covered, give effective dates: Part A: MO _____ /Day _____ /Year _____ Part B: MO _____ /Day _____ /Year _____

15. Is patient related to the provider of services? Yes No If yes, state the relationship _____

16. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

Date _____ / _____ / _____ Signature of Student _____

Date _____ / _____ / _____ Signature of Patient _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to any provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Date _____ / _____ / _____ Signature _____

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM:

1. An initial claim is being submitted for a different family member.
2. A new claim is being submitted for a completely different illness or injury.

HOW TO FILE A CLAIM:

1. Complete the applicable items on the reverse side.
2. Promptly mail this form with any itemized bills to Health Special Risk, Inc.
3. If you receive additional bills on this claim after you have mailed this form, it is not necessary to complete another form.
4. Identify bills by adding the following information:
 - College's Name and Policy Number
 - Student's Name and Social Security Number
 - Patient's Name

MAIL ALL CLAIMS TO:



**Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007**

Please remember to always make a copy of your claim forms before mailing to our office.



Wells Fargo Study Abroad Insurance Program

HSR Plaza
4100 Medical Parkway
Carrollton, Texas 75007
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free 1-866-523-3183

Email: WFstudyabroad@hsri.com

TO BE COMPLETED BY STUDENT

School Name: _____ Policy # _____

1. Student Name _____ Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____

2. Mailing Address _____
Number Street City State Zip

3. Permanent Address _____
Number Street City State Zip

4. Local Phone (_____) _____ Home Phone (_____) _____ Email: _____

5. Patient Status Male Female Single Married

6. Is this claim for a dependent? Yes No If yes, give name _____
Relationship _____ Date of Birth _____ - _____ - _____

7. Name of Physician _____ Date of Initial Service _____ - _____ - _____

8. Description of illness or injury _____

9. Has the patient been treated for the above condition(s) in the last 6 months? Yes No
If yes, give condition(s) treated for and date(s) of treatment _____

10. Is this claim the result of an accident? Yes No If yes, give date of accident _____ - _____ - _____
Where did the accident occur? _____
How did the accident happen? _____

11. Is this claim the result of a work related injury? Yes No

12. Is this claim the result of intercollegiate sports? Yes No

13. Is the patient covered for benefits (other than this policy) by any of the following?
 Yes No Any individual, Blanket or Short Term Medical Insurance?
 Yes No Group Health Benefits of an kind through an employer, spouse's employer or parent's employer?
 Yes No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

If any of the above apply, please complete the following:

Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____
Name Relationship
Insurance Co. or Benefit Plan _____ Sponsor or Employer _____
Insurance Co. Address _____ Sponsor Address _____
Telephone (_____) _____ Plan/Group Number _____ Sponsor Telephone (_____) _____
If Blue Cross, show Group and Certificate No. from Blue Cross ID card _____
Group # Certificate

14. Is patient covered under MEDICARE? (please mark all that apply): Part A Part B Not Covered
If covered, give effective dates: Part A: MO _____ /Day _____ /Year _____ Part B: MO _____ /Day _____ /Year _____

15. Is patient related to the provider of services? Yes No If yes, state the relationship _____

16. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

Date _____ / _____ / _____ Signature of Student _____

Date _____ / _____ / _____ Signature of Patient _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to any provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Date _____ / _____ / _____ Signature _____

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM:

1. An initial claim is being submitted for a different family member.
2. A new claim is being submitted for a completely different illness or injury.

HOW TO FILE A CLAIM:

1. Complete the applicable items on the reverse side.
2. Promptly mail this form with any itemized bills to Health Special Risk, Inc.
3. If you receive additional bills on this claim after you have mailed this form, it is not necessary to complete another form.
4. Identify bills by adding the following information:
 - College's Name and Policy Number
 - Student's Name and Social Security Number
 - Patient's Name

MAIL ALL CLAIMS TO:



**Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007**

Please remember to always make a copy of your claim forms before mailing to our office.