



**Wells Fargo Study Abroad
Inbound/Outbound
Insurance Program**

- 1. Please fully complete this form
- 2. Attach itemized bills
- 3. Mail to: *Health Special Risk, Inc.*

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

**Travel Assistance and Medical Emergency
US or Canada Toll Free
(800) 626-2427
Outside US or Canada Call Collect
(713) 267-2525**

Email: WFstudyabroad@hsri.com

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

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. Best Contact Phone Number, Including Area Code (____) _____ Email: _____

5. Gender Male Female 6. Patient Status Single Married

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

Relationship _____ Date of Birth _____ - _____ - _____

8. Describe the conditions that caused this claim: (Select one and attach additional pages if needed): Illness Injury Death
Date of Initial Treatment _____ - _____ - _____

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 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 (____) _____

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.

Issue reimbursement directly to Participating Organization _____

Issue reimbursement directly to Insured

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

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.