Student Medical Insurance Claim Form

This claim form is to be used only if your provider did not file claims directly to GBG on your behalf. Return this form along with fully itemized bills and diagnosis to the address below. **Claims must be received by GBG Administrative Services within ninety (90) days after first day of treatment.**

Submit claims or claims appeal by:

- **Web:** www.gbg.com
- **Mail:** GBG Administrative Services
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610
- **Fax:** +1.949.271.2330
- **Email:** eclaims@gbg.com

A. Member Information		
Name (Last, First, MI):		
School Name:	Member ID:	
Address:		
City:	State:	Zip:
Phone Number:	Alternate Number:	
E-Mail Address:		
B. Patient Information		
Patient Name:	Sex: ☐ Male ☐ Female	
Date of Birth:	E-Mail Address (if different than above):	
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent Child		
Date of Illness:	Describe symptoms:	
Is this claim for Maternity treatment? ☐ Yes ☐ No	Name of Treating OB/GYN:	
Date of last menstrual period:	Indicate delivery date:	
Name Physician/Facility First Consulted:	Date you first consulted a physician:	
Address Physician/Facility First Consulted:		
Have you ever sought treatment for this illness in the past: ☐ Yes ☐ No If yes, please describe past treatment and dates of treatment:		
If treated in your Home Country for this condition/symptoms or a similar condition, indicate the treatment recommended/ medication prescribed and date first treated:		
Please provide your Home Country details:		

If Condition is related to an Injury - Please complete the Section Below	
Date of Injury:	Describe where and how injury occurred:
Is the Injury related to: ☐ Auto Accident (attach copy of Police report) ☐ Work related injury ☐ School sponsored trip/ Activity During practice or Play of an Intercollegiate Sport (attach copy of school injury report) ☐ Sport/ Activity outside of School	
If a motor vehicle injury, list names of all drivers and Companies Insuring all drivers and or vehicle's:	
Have you ever sought treatment for this injury in the past? ☐ Yes ☐ No	

C. Other Insurance Information	
Does the patient have other Insurance: ☐ Yes ☐ No	Other Insurance Company's Name and address:
	Policy Holders Name for other coverage:
Is this a Group health Insurance Plan? ☐ Yes ☐ No	Other Insurance carrier's Policy Number and effective date:
Please complete the information below if the patient is covered by Medicare	
Medicare ID Number:	Is the patient eligible for: ☐ Part A ☐ Part B ☐ Part A & B ☐ Part D

D. Payment Information
Member will only be reimbursed if acceptable proof of payment is submitted with claim. For member: Acceptable proof of payment includes receipts from the Provider(s) and **itemized** billings noted for hospital or physicians. For Hospital Charges: All hospital submissions must be itemized on a UB-92 form with proof of payment (box 54) completed. For Physiciancharges: All physician submissions must be itemized on a HFCA/CMS-1500 form with proof of payment (box 29) completed.
Please make payment to: ☐ Member ☐ Provider (assignment of benefits must be completed on the itemized bill in box 12 and 13 of the HFCA/CMS-1500 or a "Y" in box 53 on the UB-92)
Send Check and Explanation of Benefits to:
☐ Member address on Section **A**
☐ Other Mailing Address:
☐ Send by Electronic Transfer (US Bank Accounts only):
Name on Account (must be subscribersbank account):
Name and Address of Bank:
Bank Routing Number:
Account #:

E. Authorization and Signature Required	
I authorize any health care provider, medically related facility, health care plan, insurance company, and the Medical Information Bureau and their representatives to give GBG Claims/Trawick Insurance Company or their agent's any and all information, including complete medical history records and mental health and substance abuse records, for consideration of this claim and all future claims. A photocopy of this form shall be just as valid as the original. I hereby certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for the charges incurred by the above named member.	
Member Signature:	Date:
Member/Guardian's Signature if patient is a Minor:	Date:

FRAUD WARNING: Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Please submit your current Passport and VISA along with this claim form.

Fair Processing Notice
The GBG Group includes insurance companies, brokering and management companies, as well as assistance and operations companies. We respect your privacy and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at https://www.gbg.com/#/AboutGBG/PrivacyPolicy and we would advise you to read the policy so you understand your rights and your personal data use by the GBG Group.