

How to Submit Claims to CHP Student Health for Reimbursement (Students)

If you have paid for medical or counseling services out-of-pocket, here are the steps to fill a claim for reimbursement. This is only if you want the insurance company to pay you directly, not the provider.

1. First, you need a referral from Health and Counseling Services every academic year (Sept. 1) if you are seeing a specialist in NYC. You need this referral before you see the specialist.
2. Your provider should have provided you with a statement that includes the procedure and diagnostic codes needed for insurance billing and indicates that you paid in full (receipt of payment).
3. Fill out the CHP Claim form.
4. Send the statement/invoice from your provider, the claim form and a letter that includes your name, insurance ID# and instructions for the insurance company to reimburse you directly to:
CHP Student Health
2077 Roosevelt Avenue
Springfield, MA 01104



Student Insurance Claim Form

Upon completion, send this form to:

Consolidated Health Plans, Inc.
2077 Roosevelt Ave
Springfield, MA 01104
Fax (413) 733 - 4612

School Name: _____			
Student Name:	Member ID Number:	Date of Birth:	
Student Address*	City	State	Zip
Email:	Telephone:		

***Note: All address changes must be done through your plan sponsor.**

Is this claim for your dependent? YES NO

Dependent's Name: _____ Date of Birth: _____

Do you, your dependents, or your parents have any other insurance or medical plan that covers this condition? YES NO

If yes, please enter the name of the insurance company: _____

1. For an Annual/Routine Examination: YES NO

2. For an Illness/Prescription:

Please describe symptoms: _____

Date of illness: _____

Date you first consulted a physician for this illness: _____

Have you ever sought treatment for this illness in the past: YES NO

If yes, please describe past treatment and dates: _____

3. For an Injury:

Please describe how injury occurred: _____

Where did the injury occur (home, work, etc) _____

Date of injury: _____

What body part was injury (include right or left if applicable) _____

Was the injury a result of an auto accident? YES NO

Were you injured while working on the job? YES NO

Were you injured during practice or play of an intercollegiate sport? YES NO

If yes, signature of athletic director: _____

Have you ever sought treatment for this injury in the past? YES NO

If yes, please describe past treatment and dates: _____

Were you treated by Student Health Services and referred for this condition? YES NO

Seen by: _____

If not referred, why? _____

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Consolidated Health Plan or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just as valid as the original. I authorize Consolidated Health Plans or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

Signature of Claimant

Date