

MICHIGAN TECH UNIVERSITY INJURY REPORT

HEALTH CLAIM TRANSMITTAL

2009-126-8

INSURED INFORMATION				
Last Name:		First Name:		Middle Initial:
Student Insurance ID# or Social Security#:		Home phone #:		Birth date:
Name of Sport Playing While Injured:		( )		/ /
Street address:		P.O. box:	City:	State: ZIP Code:
PATIENT INFORMATION (IF DIFFERENT FROM ABOVE)				
Last Name:		First Name:		Middle Initial:
Street address:		City:		State:
P.O. box:		ZIP Code:		Birth date:
Patient's relationship to student:				
<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child
<input type="checkbox"/> Other				
ACCIDENT INFORMATION				
<input type="checkbox"/> IC Sport Accident:		<input type="checkbox"/> Club Sport Accident:		Date Occurred:
Details of Accident:				
INJURY INFORMATION				
How did the injury occur?				
Have you suffered the same or a similar condition in the past?				
If Yes, and if you were treated for it, please give the name and address of the physician who treated you.				
Physician's Name:		Physician's Address:		Date Treated:
<b>I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER MEDICAL PROVIDER TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM TO UNITEDHEALTHCARE INSURANCE COMPANY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</b>				
Insured's Signature:			Date of Release:	
OTHER INSURANCE INFORMATION				
(If the patient is covered by another insurance plan, please complete the following.)				
Name of person carrying other insurance:		Subscriber # or Social Security#:		Name of other insurance carrier:
Other Insurance Policy #:		Other Insurance Phone #:		Policy Holder Date of Birth:
<b>ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.</b>				

Insured's Signature:

Date: