

KLAIS & COMPANY, INC.
Medical and Prescription Drug Claims Form



Student Information

Student Name _____ Social Security Number _____
Last First Middle Initial

(School) Student Street Address _____

(School) City, State & Zip _____

(Home) Student Street Address _____

(Home) City, State & Zip _____

Claim is for Student Student's Spouse Student's Child _____
Name

Is patient covered for benefits (other than this policy) by any Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:

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

Insurance Company Benefit Plan _____ Plan/Group Number _____

Insurance Company Address _____ Telephone (____) _____

Is this claim the result of an accident? Yes No If yes, give date of accident (MM/DD/YY) ____/____/____

PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM.

Student Authorization

PLEASE READ AND SIGN I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself and/or dependents. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X _____ Date (MM/DD/YY) ____/____/____

Klais & Company, Inc. 1867 West Market Street • Akron, OH 44313-6977 • Telephone: (800) 331-1096 • Fax: (330) 867-0827



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