

Date: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

PATIENT ACCT: \_\_\_\_\_

GROUP NAME/NUM: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

THIS LETTER TO BE COMPLETED BY INSURED!

THE CLAIMS OFFICE HAS RECEIVED A CLAIM FOR THE ABOVE MENTIONED PATIENT. BEFORE BENEFITS CAN BE PROPERLY CONSIDERED, THE FOLLOWING INFORMATION IS NEEDED.

YOUR PLAN PROVIDES COVERAGE FOR DEPENDENTS, WHO ARE OVER THE LIMITING AGE FOR A DEPENDENT CHILD, WHEN THEY ARE A FULL-TIME STUDENT AND DO NOT HAVE THEIR OWN COVERAGE.

IS THIS DEPENDENT CURRENTLY A FULL-TIME STUDENT? YES\_\_\_ NO\_\_\_

IF YES, NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

NUMBER OF HOURS ATTENDING \_\_\_\_\_

SUBMIT A COPY OF THE OFFICIAL REGISTRATION FOR THE CURRENT SEMESTER.

IF NOT, WHEN WAS HE/SHE LAST ENROLLED? \_\_\_\_\_

HOW MANY HOURS HAVE BEEN COMPLETED IN THE LAST TWELVE MONTHS?  
\_\_\_\_\_

SEND THIS INFORMATION AT THE BEGINNING OF EACH SCHOOL SEMESTER TO AVOID ANOTHER REQUEST OR DELAY OF CLAIM PROCESSING.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS LETTER, PLEASE CONTACT OUR OFFICE. THANK YOU FOR YOUR COOPERATION AND ASSISTANCE.

SINCERELY,

CLAIMS DEPARTMENT