Student Health Insurance

Claim Form Instructions

If the medical service provider did not file a claim on your behalf, please fill out the Claim Form on the following page. Submit all claim documents to our claims administrator, SISCO Benefits **within 90 days** from the date of service. The Company maintains its right to investigate and verify that the eligibility requirements have been met for claims processing purposes.

Procedures when submitting the claim:

1. Obtain a copy of the **itemized bill and/or payment receipts**.
2. Indicate your current mailing address in Section A. **Please note check reimbursements will be mailed to the address indicated in this field.**
3. Complete section B of the claim form that corresponds to your visit.
4. Email all documents to SISCO Benefits at isoservice@siscobenefits.com

Claims are usually processed within 20 - 30 business days, while some claims may take up to 45 business days to process. Once your claim is processed, you will receive an email notification from SISCO Benefits. You can check claim status by visiting www.isoa.org and clicking "My claims".

If you have any concerns please feel free to email SISCO Benefits at isoservice@siscobenefits.com or call (833) 577-2586 between 8:30 A.M. and 7:00 P.M. EST Monday through Thursday and between 8:30 A.M. and 5:00 P.M. EST Friday.

Upon completion, send this form to:
SISCO Benefits: PO Box 3190
Dubuque, IA 52004
Email it to isoservice@siscobenefits.com

ISO Student Health Insurance Claim Form

Section A:

School Name (if applicable):		
Member Name (First Name Last Name):		
Insurance ID Number:	Date of Birth (MM/DD/YYYY):	
Email:	Telephone:	Visa Type:
Address:*		
City:	State:	Zip Code:

***Note: Did your mailing address change? If yes, please also update in your ISO account.**

Section B:

1) **Do you or your dependents have any other insurance or medical plan that covers this condition?** ☐ YES ☐ NO
   a. If yes, please provide the insurance ID card of your other insurance plan.

2) **Is this claim for your dependent?** ☐ YES ☐ NO
   a. Dependent's Name: _____ b. Dependent Date of Birth (MM/DD/YYYY): _____

3) **For an Illness/Prescription Claim**:
   a. Date (MM/DD/YYYY) when symptoms first occurred: _____
   b. Describe symptoms: _____
   _____
   c. Date (MM/DD/YYYY) you first consulted a physician:_____
   d. Have you received any previous treatments for this illness? ☐ YES ☐ NO
   e. If yes, please describe past treatment and dates (MM/DD/YYYY): _____
   _____

4) **For an Injury Claim**:
   a. Date (MM/DD/YYYY) of the injury: _____
   b. Where the injury occurred (home, work, etc): _____
   c. Describe how injury occurred: _____
   _____
   d. Was the injury a result of an auto accident? ☐ YES ☐ NO
   e. Were you injured while working on the job? ☐ YES ☐ NO
   f. Is your injuryrelated to sports participation? ☐ YES ☐ NO
      If yes, ☐ Intercollegiate ☐ Intramural ☐ Club ☐ Other
   g. Have you received treatment for this injury inthe past? ☐ YES ☐ NO
   h. If yes, please provide the date (MM/DD/YYYY) for treatment: _____
   i. Were you treated by the Student Health Center and referred to another provider for this condition? ☐ YES ☐ NO

5) **Was the visit for Preventive & Wellness treatments and Immunization?** ☐ YES ☐ NO

6) **For Student Health Center visits ONLY: Did you pay this bill on your student account?** ☐ YES, submit proof of payment ☐ NO

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits **payable** for this claim to SISCO Benefits or its pay or for which it is an authorized plan administrator. A photocopy of this form shall be just a valid as the original. I authorize SISCO Benefits 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 (MM/DD/YYYY) _____

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.