BCS INSURANCE COMPANY

College/University:		Policy Number:
Name of Insured:	Gender: ☐ Male ☐ Female	Social Security Number:
Mailing Address: (street, city, state & zip)		Date of Birth:
		Home Phone: ( )
		E-mail Address:
Patient's Name:	Date of Birth:	Relationship to Insured:
Date of Accident or Commencement of Sickness:		
Please describe in completed detail the Accident or Sickness (how, when & where) Use additional paper if needed:		
Was your accident due to participation in or practice for intercollegiate sports? Yes ☐ No ☐ Work related injury? Yes ☐ No ☐ Have you had any prior treatment for this condition? Yes ☐ No ☐ If Yes, what was the date? _____		
Were you referred by the Student Health Center for these services? Yes ☐ No ☐ If No, explain why.		

BCS

INSTRUCTION FOR REPORTING A CLAIM

Answer all questions completely

Attach all original, itemized medical bills concerning this claim

Providers should use standard HCFA & UB04 forms

Mail this form, completed in full to:

ASRM, LLC
Claims Department
505 S. Lenola Road, Suite 231
Moorestown, NJ 08057
800-359-7475

Are you employed? Yes ☐ No ☐ If Yes, Employer's Name , Address, and Phone Number

Is your spouse employed? Yes ☐ No ☐

Are your expenses covered by any other insurance? Yes ☐ No ☐

Blue Cross/Blue Shield?	Yes ☐	No ☐	Your parents insurance?	Yes ☐	No ☐	Auto Insurance?	Yes ☐	No ☐
Any other medical or dental plan?	Yes ☐	No ☐	Other school insurance?	Yes ☐	No ☐	Prepaid Health maintenance plan? (HMO, HIP)	Yes ☐	No ☐
If Yes, please indicate the Name, Address and Policy Number of the Other Insurance Provider:						Other health care plan in your home country?	Yes ☐	No ☐

Have you or will you submit a claimed against any other party for damages as a result of the illness or injury described in this form? Yes ☐ No ☐

If Yes, please provide the Name, Address of the Insurance Company or Organization which sponsors the coverage.

IF PAYMENT IS TO BE MADE TO THE PROVIDER, SIGN BELOW

I hereby authorize payment of benefits to any providers of service, otherwise to me for services, but not to exceed the reasonable and customary charges for those services. I understand that I am responsible for any charge not covered by this authorization

Signed:	Date:

AUTHORIZATION TO OBTAIN INFORMATION

To all physicians, hospitals, medical service providers, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Blue Cross/Blue Shield, self-insured and prepaid health plans) and specifically

_____ Hospital(s), and Dr. _____

You are authorized to permit the BCS Insurance Company and its authorized representatives to view and obtain a copy of ALL RECORDS* including employment, law enforcement, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease of _____

Print Name of Patient

I understand the information obtained will be used by BCS Insurance Company to determine eligibility for insurance and benefits claimed under the insured's policy. I consent to rediscolsure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred or relayed to any other person not specified in this form without my consent.

I understand this authorizing may be revoked by written notice to BCS Insurance Company, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below.

I know I may request to received a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

*Limitations if any:

Date	Signed

Signature Required