



Finally, an exam you need!

Get reimbursed for one routine eye exam at a preferred (in-network) vision provider if you're insured on the WPI Student Health Insurance plan.



To be reimbursed, please submit copies of the following:

- Completed Claim Information Form
- Itemized bill from your provider that includes:
 - Insured's name
 - Insured's identifying information (SR ID, date of birth, etc.)
 - Provider name, address and tax ID number
 - Date of service when services were rendered
 - If possible, procedure and diagnosis code. If not available, a description of each service rendered
- Proof of payment that includes:
 - Front and back copy of a canceled check
 - Credit card statement showing payment for services billed (cardholder information and institution name must be present on the credit card statement)
 - Bank card statement showing payment for services billed (account holder information and institution name must be present on the bank account statement)
 - Cash payments will be verified by UnitedHealthcare Student Resources

Your benefits

Benefits are reimbursable for one adult routine eye exam per policy year at a preferred (in-network) vision provider.

Benefits would be considered at 80% of the allowed amount for both preferred and out-of-network providers.

Vision benefits under the medical policy are not coordinated with the WPI optional vision plan.



To find a vision provider, visit uhcsr.com/myaccount.



Upload documents at uhcsr.com/myaccount or email to customerservice@uhcsr.com.

UnitedHealthcare Student Resources does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

ATTENTION: Language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Usted tiene a su disposición servicios de asistencia en otros idiomas, sin cargo. Llame al 1-866-260-2723.

注意：免费提供语言协助服务。請致電 1-866-260-2723。

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United
Healthcare



If you are completing this form online, please print the form, sign, and follow one of the submission methods below. Press the tab button to move from one box to the next. The text font will automatically decrease in size to fit the allotted space if the data entered is larger than the box provided. If additional space is needed, you can use a separate sheet of paper and attach it to this form.

CLAIM INFORMATION FORM - UNITEDHEALTHCARE STUDENTRESOURCES

INSURED STUDENT INFORMATION					
Last Name:	First Name:	Middle Initial:	Male Female	SR ID#(refer to your ID card):	
Home phone #:	Date of Birth(mm/dd/yyyy):	Email Address:			
Mailing Address:	P.O. Box:	City:	State:	ZIP Code:	
PATIENT INFORMATION (IF DIFFERENT FROM INSURED)					
Last Name:	First Name:	Middle Initial:	Male Female	SR ID#(refer to your ID card):	
Home phone #:	Date of Birth(mm/dd/yyyy):	Email Address:			
Mailing Address:	P.O. Box	City:	State:	Zip Code:	
Patient's relationship to student: Self Spouse Child Other (please explain)					
INJURY/SICKNESS INFORMATION					
Type of Accident (if applicable) : Auto Intramural Sport Interscholastic Sport Intercollegiate Sport Club Sport Work <input type="checkbox"/> Other:					
Date Injury/Sickness occurred :		Type of Sport (Football, Baseball, etc. if applicable):			
Describe how Injury/Sickness occurred (give all possible details). If accident is due to an injury, must be a bodily injury due to an accident:					
Body Part (s) Injured (if applicable):					
Has claimant suffered the same or a similar condition in the past? Yes No If Yes, and if you were treated for it, please provide information:					
Physician's Name:		Physician's Address:		Date Treated (mm/dd/yyyy):	
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 United Healthcare Insurance Company. A photocopy of this authorization shall be as valid as the original.					
Insured's Signature:				Date:	
OTHER INSURANCE INFORMATION					
Is the patient covered by another Insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked "Yes", please complete the section below.					
Name of Policyholder or person carrying other Insurance:		Subscriber #:		Name of other Insurance Carrier:	
Other Insurance Policy #:		Other Insurance Phone #:		Policyholder Date of Birth(mm/dd/yyyy):	
NOTICE: PLEASE REFER TO FRAUD WARNING STATEMENT(S) INCLUDED ON THE SECOND PAGE OF THIS FORM					
Insured's Signature:				Date(mm/dd/yyyy):	
STUDENT HEALTH CENTER REFERRAL					
A Referral was received: <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Center Closed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Center Closed? <input type="checkbox"/> Yes <input type="checkbox"/> No	I was more than 50 miles from campus: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other (please explain):	

Guidelines for Submitting Claims to UnitedHealthcare StudentResources

Claim Instructions: The bill needs to include the diagnosis code (s), procedure code (s), date of service, and billed amount. Clip, do not staple, all bills to this completed form. **Member must include Proof of Payment for reimbursement.**

Prescription Claims: A Claim Form is not required for prescription claim reimbursement. Member needs to submit the receipt or computer printout with information which includes: medicine name, date of purchase, and price. Include your name, address, and SR ID# (7 digit number on your insurance ID card) **and member must include Proof of Payment for reimbursement.**

Proof of Payment: If payment was made by check, please provide a copy of the front and back of the cancelled check. For all credit card payments, the credit card statement showing the cardholder's full name, institution name and payment information for each date of service is required. If payment was made with an ATM or Debit card, the bank statement showing the accountholder's full name, institution name and payment information for each date of service is required. United Healthcare StudentResources will call the provider of services to verify all cash payments.

The Claim Form along with any other documentation can be submitted using one of the following methods:

Mail: UnitedHealthcare StudentResources, P. O. Box 809025, Dallas, TX 75380-9025 (This is listed on your ID card)

Email: A scanned copy of the completed form to SI.DRG@uhcsr.com **Questions?** Call Customer Service Toll Free Number: 800-767-0700

The following notice is applicable to any state not individually listed below

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and/or civil penalties.

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

AK- A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ - 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.

AR- 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.

CA- 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.

CO – 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.

DE- Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC- It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL - 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.

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

IN - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY- 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.

LA - 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.

ME - IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

MD – 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.

MN - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH - 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.

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

NM - 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 civil fines and criminal penalties.

NY - 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PA - 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.

PR – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island- 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.

TN - 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.

TX – 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.

VA - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. 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.

WA - 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.