WebTPA
An AmWINS Group Company
P. O. Box 2415
Grapevine, TX 76099-2415
FAX (469) 417-1969

STUDENT HEALTH CLAIM FORM
Firebird International Insurance Group

SCHOOL/ORGANIZATION ______________________ **GROUP NUMBER** __________

Claim submitted with completed Claim Form is for: ☐ *Primary Insured* ☐ *Spouse* ☐ *Dependent*
Select the type of claim you are filing for: ☐ *Medical Claim* ☐ *Prescription Drug Claim*

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING. A STUDENT HEALTH CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM SUBMITTED. ATTACH ALL BILLS/CORRESPONDENCE IF YOUR PHYSICIAN IS NOT FILING THE CLAIM FOR YOU. IF CLAIM IS THE RESULT OF AN ACCIDENT, PLEASE FULLY COMPLETE THE *ADDITIONAL INFORMATION* SECTION OF THIS CLAIM FORM.

PRIMARY INSURED INFORMATION

Insured's Name ______________________ Date of Birth __________

Student/Policy ID ______________________ Gender (check one) ☐ Male ☐ Female ☐ Other

Phone Number ______________________

US Mailing Address ______________________
Street Name (Include Street Number or PO Box) City State Zip

CLAIMANT INFORMATION

Claimant's Name ______________________ Date of Birth __________

Phone Number ______________________ Gender (check one) ☐ Male ☐ Female ☐ Other

US Mailing Address ______________________
Street Name (Include Street Number or PO Box) City State Zip

Is this a disabled dependent? (check one) ☐ Yes ☐ No
**** Please provide Physician's Statement for proof of disability.***

ASSIGNMENT OF BENEFITS

Indicate to whom payment is issued to:
- ☐ Balance is due to the attending provider/pharmacy. Make payment to the address indicated on the billing statement
- ☐ Balance is due to the patient/insured. Make payment to the claimant listed above.

ADDITIONAL INFORMATION

Is the patient covered by other insurance? ☐ Yes ☐ No
If yes, complete the following information:

Insured Name ______________________

Insured Company Name ______________________

Policy Number ______________________

Policy Effective Date ______________________

Place, Date, and Description of Accident/Remarks:
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AUTHORIZATION FOR RELEASE OF INFORMATION

TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS. This authorizes you to give WEB-TPA, or its authorized representative who is employed to assist in the evaluation of my claim, any information, date or records you may have regarding me, my employment or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by WEB-TPA. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted as effective and valid as the original. By signing, this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on the entire form is correct.

Patient/Authorized Person's Signature ______________________ Date __________

Primary Insured's Signature ______________________________ Date ______________

CLAIM FILING INSTRUCTIONS

ONCE THE STUDENT HEALTH CLAIM FORM HAS BEEN COMPLETED IN FULL YOU CAN SUBMIT YOUR CLAIM TO THE BELOW MAILING ADDRESS OR BY FAX TO THE NUMBER SHOWN BELOW. PLEASE CONTACT CUSTOMER SERVICE IF YOU HAVE ANY QUESTIONS REGARDING HOW TO FILE YOUR CLAIM.

Claim Mailing Address	Claims Fax Number	Customer Service Number
WebTPA P.O. Box 2415 Grapevine, TX 76099-2415	(469) 417-1969	**WA**: 206-909-8550 **OR**: 503-729-7447

Medical Claims

Each claim submission requires the itemized billing statement in order to be considered for payment. The required documentation must include:

- Claimant/Patient Name
- Claimant/Patient Date of Birth
- Provider Name, Address, Tax ID Number (Must include a listing of all physicians who provided services)
- Date of Service
- Diagnosis and Procedure Code(s)
- Amount of charges for each procedure

If the billing statement you received does not include this information, please contact the provider(s) and request the fully itemized billing form.

Prescription Drug Claims

Each claim submission requires the itemized prescription drug receipt in order to be considered for payment. The required documentation must include:

- Claimant/Patient Name
- Pharmacy Name
- Prescription Rx Number
- NDC code
- Date of service
- Dosage and/or quantity dispensed
- Prescribing physician name
- Amount of charges for each prescription

If the billing statement you received does not include this information, please contact the pharmacy and request the fully itemized receipt that provides this information.