WELWITCHIA STUDENT HEALTH CLAIM FORM

Please return this form and any attachments to:

WELWITCHIA STUDENT HEALTH

P.O. Box 98604, Pelican Square

Windhoek Namibia

Email: studenthealth@welwitchia.com.na

TO BE COMPLETED BY MEMBER (Please Print)

1. School Name
Welwitchia Health Training Centre

2. Policy Group Number
PHO00126

3. Member's Student ID Number

4. Member's Name

5. Member's Birthdate *(MM/DD/YYYY)*

6. Member's Address

☐ Programme and Campus

7. Member's Daytime Telephone Number
( )

8. Patient's Name

9. Patient's Student ID Number

10. Patient's Birthdate *(MM/DD/YYYY)*

11. Patient's Relationship To Member
☐ Self ☐ Spouse ☐ Child ☐ Other

12. Are your or any family members' expenses covered by another group health plan,
☐Yes If Yes, go to Section 13 ☐No If No, go to Section 17

13. List policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:
Note: If you do have another insurance plan, Welwitchia Student Health is considered your secondary plan

14. Member's ID Number

15. Member's Name

16. Member's Birthdate *(MM/DD/YYYY)*

17. Is claim related to an accident? ☐ Yes ☐ No If Yes, go to Sections 18-24 If No, skip to Section 25

18. COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM

19. Summary of the Accident:

20. Location where accident occurred:

21. Was injury due to practice/play of Welwitchia sponsored sport?
☐ Yes ☐ No If Yes, answer Section 22. If No, skip to Section 23.

22. Name of Sport?

23. Was injury work related?
☐ Yes ☐ No

24. Is condition due to an road traffic accident?
☐ Yes ☐ No

If yes, please attach details.

GO TO SECTION 29 TO COMPLETE FORM

29. Attach itemized bills. The bills must
- patient's name
- condition being treated
- dates(s) of service(s)
- type of service
- proof of payment

If you have submitted a request for benefits to another insurance plan, attach a copy of the bills you submited to the other plan and the explanation of benefits you received from the other plan.

Retain copies of your bills for your record.
Sign and date below.

25. COMPLETE THIS SECTION FOR MEDICAL/DENTAL CLAIMS

Instructions: Check claim type in Section 26. Go to corresponding section. Complete claim form with signature and date. Attach receipt as described in Section 29. Send claim to Welwitchia Student Health at address located at top side of this form.*

26. ☐ **Preventative Dental** (Go to Section 29)
☐ **Vaccination** (Go to Section 29)
☐ **Mental Health** (No referral required) (Go to Section 29)
☐ **Complimentary Medicine/Physical Therapy** (Go to Section 27)
☐ **Other** (Go to Section 28)

27. COMPLIMENTARY MEDICINE / PHYSICAL THERAPY CLAIM

Were you treated at University Health Services for this
☐ Yes ☐ No

Did you receive a referral? ☐ Yes ☐ No

28. OTHER CLAIM

Were you treated at University Health Services for this
☐ Yes ☐ No

Did you receive a referral? ☐ Yes ☐ No

Were services obtained outside Welwitchia ☐ Yes ☐ No

Were services obtained during a break period? ☐ Yes ☐ No

SIGNATURE ______________________________ **DATE** ____________________

* Claims can be mailed to address located at top of this form *or* emailed directly to studenthealth@welwitchia.com.na

* Welwitchia Student Health Representative