EXCESS MEDICAL BENEFIT CLAIM REPORT

Instructions:

PART A: PARTICIPANT DATA
Department contact will complete Part A and distribute 3 copies as follows: (1) Copy to Health Care Provider; (1) Copy to Risk Management Insurance Programs; (1) Copy retained in your departmental file(s).

PART B: ATTENDING PHYSICIAN'S STATEMENT
Health Care Provider will complete and return copy and all applicable billings to:

SOUTHERN ILLINOIS UNIVERSITY
RISK MANAGEMENT INSURANCE
PROGRAMS
MAILCODE 6801
CARBONDALE, IL 62901
PHONE: 618/453-6105 FAX: 618/536-3404

PART A: PARTICIPANT DATA

Name of Covered Program/Camp:	**Sponsoring SIU Department**:	**Location**:
Name of Claimant:		**Male** **Female**
Date of Birth of Claimant:	**Name of Parent if Claimant is a Minor**:	
Street:	**City:**	
State:	**Zip Code**:	**Telephone**:
Primary Insurance Policy Information (Name, ID#, Group#, Phone# and address):		
Program Opening Date:	**Program Closing Date**:	**Name & Phone Number of Department Contact**:
Date and Hour of Accident or Sickness:	**Nature of Injury or Sickness**:	
How and Where did Accident Occur? (Accident Claims Only):		
Was Claimant in a University-Sponsored Program Activity at the Time of Incident? **(Accident Claims Only)**:		

PART B: ATTENDING PHYSICIAN'S STATEMENT

Date of Service:	**Name & Address of Facility Where Services Were Rendered**:
Diagnosis or Nature of Illness/Injury:	
Signature of Physician or Supplier:	**Date:**
Your Patient's Account Number:	**Your Employer ID Number/Social Security Number**:
Physician or Supplier's Name, Address, Zip Code & Telephone Number:	