WELLFLEET

Claim Form Instructions

If the medical service provider did not file a claim on your behalf, please fill out the Claim Form on the following page. Please submit the claim form, itemized bill, and relevant documents to our claims administrator, Wellfleet within 90 days from the date of service. The Company maintains its right to investigate and verify that the eligibility requirements have been met for claims processing purposes.

Procedures to submitting the claim:

- Before submitting the claim, please obtain a copy of the itemized bill. An itemized bill is a document provided by the physician's office that will have the name of the facility, the date of service, patient's personal information, diagnosis code(s), CPT code(s), tax ID number and total charge of the services.
- Indicate your current mailing address in Section A. Please note reimbursements are provided in a form of a check and will be mailed to the address on file.
- You should complete section B of the claim form that corresponds to your visit. For prescription claims, complete either the sickness or injury section that is related to your treatment and attach a copy of your prescription slip. If you need additional space to answer a question, you can submit it on a separate sheet of paper.
- Once you have completed the claim form. Please submit all documents to Wellfleet using one of the following methods:

  Email to ISOclaims@wellfleet-iso.com
  Fax to (413) 452-5485
  Mail to Wellfleet Group, LLC at PO Box 15369 Springfield, MA 01115-5369

- Claims usually are processed within 10 business days, while some claims may take up to 30 business days to process. Once your claim is processed, you will receive an email notification from Wellfleet. You can check claim status by visiting www.wellfleet-iso.com and clicking "Check Claims Status".

If you have any concerns please feel free to email Wellfleet at ISOclaims@wellfleet-iso.com or call 855-664-5837 between 8:30 A.M. and 7:00 P.M. EST Monday through Thursday and between 8:30 A.M. and 5:00 P.M. EST Friday.

Upon completion, send this form to:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
Fax: (413) 452-5485
Phone: (855) 664-5837
Email it to ISOclaims@wellfleet-iso.com

ISO Student Insurance Claim Form

Section A:

School Name (if applicable):		
Member name (First Name Last Name):		
Insurance ID Number:	Date of Birth (MM/DD/YYYY):	
Email:	Telephone:	Visa Type:
Address:*		
City:	State:	Zip code:

***Note: Did your current mailing address change? If yes, please also update in your ISO account.** Yes No

Section B:

1) Is this claim for your dependent? Yes No

   Dependent's Name: ______________________________ Dependent Date of Birth (MM/DD/YYYY): ____________________________________

2) Do you or your dependents have any other insurance or medical plan that covers this condition? Yes No

3) **For an Illness Claim**:

   Please describe symptoms and date (MM/DD/YYYY) when symptoms first occurred: ____

   ____

   Date (MM/DD/YYYY) you first consulted a physician for this illness: ____

   Have you received any previous treatments for this illness? Yes No

   If yes, please describe past treatment and dates (MM/DD/YYYY):

4) **For an Injury Claim**:

   Date (MM/DD/YYYY) of the injury and where the injury occurred (home, work, etc): ____

   Please describe how injury occurred: ____

   ____

   Was the injury a result of an auto accident? Yes No

   Were you injured while working on the job? Yes No

5) Is your injury related to sports participation? Yes No

   If yes, Intercollegiate Intramural Club Other

6) Have you received treatment for this injury in the past? Yes No

   If yes, please provide the date (MM/DD/YYYY) of treatment: ____

7) Was the visit for Preventive & Wellness treatments and Immunization? Yes No

8) Were you treated by Student Health Services and referred to another provider for this condition? Yes No

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Wellfleet Group, LLC or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just a valid as the original. I authorize Wellfleet Group, LLC or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the 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 hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

Signature of Claimant: ____Date (MM/DD/YYYY) ___________________________

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

ARIZONA: 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.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: 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.

COLORADO: 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.

FLORIDA: WARNING :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.

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

MARYLAND: 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.

NEW HAMPSHIRE: 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.

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

PENNSYLVANIA: 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.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: 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.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.