

mail to: CLAIMS, E23-191, 77 Mass. Ave., Cambridge, MA 02139-4307

Use a separate claim for each patient

subscriber ID#	subscriber last name	first name	middle initial
number and street	city	state	zip
patient last name	first name	middle initial	patient date of birth month / day / year

Which plan?

1 MIT Student Traditional MIT Health Plan Flexible MIT Health Plan MIT Affiliate _____

2 Patient enrolled in a second insurance plan? Yes No If yes, ID# _____ Effective date _____
 other plan name/address _____

3 Was treatment for accident at work? Yes No If yes, date of accident _____

4 Was treatment for auto accident? Yes No If yes, date of accident _____
 If yes, name of auto insurance: _____ Policy # _____

Claims Information

Attach original itemized bill(s) showing provider name, patient, each date of service, and the charge for each service. Also attach letter of medical necessity for appliances.

provider	date of service			amount charged	date of service			amount charged
	mo	day	year		mo	day	year	

Prescription drugs (Traditional, Flexible, Students, and Affiliates ONLY)

Attach original itemized receipts showing pharmacy name and address, prescribing physician name, date of service, drug name and charges

drug name	date of service			amount charged	drug name	date of service			amount charged
	mo	day	year			mo	day	year	

Reason for prescription drug claim:

MIT Pharmacy out of stock MIT Urgent Care approved visit AND drugs After Hours discharged from hospital
 MIT Physican approved out of area visit AND drugs Drug not carried at MIT Pharmacy Other – _____

Signature

I certify that the information provided in support of this claim is complete and correct and that I have not been previously reimbursed for these services

Subscriber's signature _____ Date _____