MEDICAL/DENTAL INSURANCE CLAIM FORM

TO BE FILLED OUT BY MEDICAL PROVIDER AT THE TIME OF VISIT:

Insurance Certificate #: 4.083.739 - Nacel Open Door Student ID Number _____ (from Insurance Card)

Name of Student:	Name of Host Family:	
Street Address:	City:	State & Zip:
Email Address:	Phone number ❍ Home ❍ Cell ❍ Work	

Facility Information: ❍ Hospital ER ❍ Physician/Medical Clinic ❍ Dental Office ❍ Hospital Stay

Name of Facility:	Name of Provider:	
Street Address:	City:	State & Zip:
Phone Number:		

Reason for Claim: ❍ Illness ❍ Accident ❍ Dental Date of Injury/Accident or Onset of Illness: _____

Short description of injury, accident, or illness:

PROVIDERS:

To expedite claim payment, please complete this form and attach medical records, progress notes, or any supporting documentation along with this form to:

Send with 1500 Health Insurance Claim Form; UB-04/UB-92; or ADA Claim Form.

All preventative services excluded from coverage and should be paid at the time of service (i.e. physicals, immunizations, dental cleanings and exams).

Mail invoice and completed claim form to:

Nacel Open Door, Inc
Attn: Student Insurance
380 Jackson Street, Suite 200
St. Paul, MN 55101
P: 651-686-0080 x608 | F: 651-686-9601