Pioneer Administrative Services
Medical and Prescription Drug Claims Form

Student Information

Student Name_____SIS#_____
Last First MI

(School) City, State & Zip_____

(School) City, State & Zip_____

(Home) Student Street Address_____

(Home) City, State & Zip_____

Claim is for ☐ Student ☐ Student's Spouse ☐ Student's Child

_____
Name of Claimant

Other Insurance Information

Is patient covered for benefits (other than this policy) by any Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:

Through whom was/is your coverage provided? (i.e., parent, spouse, etc.)

_____
Name Relationship

Insurance Company Benefit Plan_____

Insurance Company Address_____

Plan/Group Number_____ Phone (____)_____

Is this claim the result of an accident? ☐ Yes ☐ No If yes, give the date of accident _____/____/____

Student Authorization

PLEASE READ AND SIGN: I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself and/or dependents. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X_____Date_____/_____/_____

Pioneer Administrative Services, A Pomco Company • PO Box 186 • Syracuse, NY 13206
Fax: 315-433-5444 • Toll Free (877) 868-9060

PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM.