Pioneer Management Systems
Medical and Prescription Drug Claims Form for Students Studying Away

Student Information

Student Name____ Student ID #________________
Last First MI

(Home) Student Street Address____

(Home) City, State & Zip____

Claim is for____
(Name of Claimant)

College Information

Bowdoin College
Brunswick, ME 04011

Other Insurance Information

Are you covered by any other 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)

____
Name Relationship

Name of Insurance Company ____

Insurance Company Address____

Plan/Group Number________________________________ Phone (____)________________

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

When was the first date of your injury or sickness? ____/____/____

Have you received treatment for this same injury or sickness prior to this date?

If yes, when? ____

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. 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 Management Systems, Inc. PO Box 9040 West Springfield MA 01090
(Fax) 413-265-2779 Toll Free (877) 868-9060

PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM AND MAIL TO PIONEER MANAGEMENT SYSTEMS, INC. IF BILLS ARE NOT TRANSLATED INTO ENGLISH, PLEASE PROVIDE A DESCRIPTION OF THE ACCIDENT OR SICKNESS.