



MEDICAL/DENTAL INSURANCE CLAIM FORM

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

Policy # (Refer to card): #3924 - Nacel Open Door
OR #3926 - French Students

Student ID Number: _____
(from Insurance Card)

Name of Student:	Name of Host Family:	
Street Address:	City:	State & Zip:
Email Address:	Phone number <input type="radio"/> Home <input type="radio"/> Cell <input type="radio"/> 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:
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PROVIDERS:

To expedite claim payment, please complete this form and attach medical records, progress notes, or any supporting documentation along with one of the following paper forms: 1500 Health Insurance Claim; UB-04/UB-92; or ADA Claim.

Mail invoice and completed claim form to:

Nacel Open Door, Inc
Attn: Student Insurance
101 5th Street East, Suite 1900
St. Paul, MN 55101
P: 651-686-0080 x608 | F: 651-686-9601

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