

SUNY AT BUFFALO INTERNATIONAL HEALTH INSURANCE
— CLAIMS RESOLUTION FORM —

1 { **Patient:** _____ **Cert. #** _____
Last First M.I.

UB Person #: _____ - _____ **D.O.B:** ____/____/____ **Sex: Male / Female**
Month / Day / Year

Phone #: (_____) _____ - _____ **E-Mail:** _____

2 { **Is the patient non-student dependant?: YES / NO — If yes complete the following:**

Name of primary on policy: _____ **DOB:** ____/____/____
Last First M.I. Month / Day / Year

Relation to Patient: _____ **UB Person #:** _____ - _____ **Cert. #:** _____

— **HIPAA release on file?: YES / NO —**

— **Claim sent for collections: YES / NO —**

3 { **If sent for Collections—Collection Agency:** _____

Address: _____ **Ph: #:** (_____) _____ - _____
Street Address City State Zip

Note Date: ____/____/____ Time: _____ AM / PM Contacted: _____ Contact Medium: Phone / Rtd Call / Fax <small>Email / In-Person / Other</small> Account #: _____ DOS: ____/____/____ Taken By: _____ Notes: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Disposition: _____	Note Date: ____/____/____ Time: _____ AM / PM Contacted: _____ Contact Medium: Phone / Rtd Call / Fax <small>Email / In-Person / Other</small> Account #: _____ DOS: ____/____/____ Taken By: _____ Notes: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Disposition: _____
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Status: _____