

# CIEE Claim Form

Please return this form and any Attachments to:

Non-completion of this form may result in delay or denial.  
Please attach all available itemized medical bills and/or receipts to the claim form.

**Chickering Claims Administrator, Inc.**  
**P.O. Box 15708**  
**Boston, MA 02215-0014**

**(Please Print)**

<b>Student/Patient Name</b>			
<b>Member ID Number</b>		<b>Date of Birth</b>	
<b>Current Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Telephone Number</b>		<b>E-mail</b>	

If Patient is covered by another insurance plan, please provide:	
<b>Name of Insurance Company</b>	<b>Policy Number</b>

**PLEASE SEND PAYMENT TO: Provider    Me    (Please attach proof of Payment)    Signature \_\_\_\_\_**

## COMPLETE THIS SECTION FOR AN ACCIDENT OR ILLNESS CLAIM

1. **Date of Accident or Illness** \_\_\_\_\_

2. **How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning. For accidents, include how, when and where the accident occurred.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. **When did the first symptom of this condition begin?** \_\_\_\_\_

4. **Have you ever had or been treated for this type of injury or illness before?** \_\_\_\_\_

5. **Name and Address of treating Physician:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

