How do I submit my insurance waiver?

- Log into <u>e-Campus</u>
- Select "URI Student Services" from the menu
- Now, select "Insurance Waiver". You will see the following message indicating the term you are



submitting a waiver for:

• Now, click "OK". You will see the following screen

	ent Services > Insurance Waiver			
udent Health Insurance Waive	r			
Health Inst	rance Waiver Request	Waiver Status:	S - Submitted, A	A - Approved, R - Rejected, C - Cancelle
Student Information				
Name: Student ID: 'Email Address:	Waiver ID:	DOB: *Phone Number:	Format: XXX Do not inclu	(XXXXXXX (Includes Area Code) de a dash within the phone number
Insurance Information				
Please provide the complete and numerical family memb 02. Group Number (If Applicable) "Policy Number/Member ID	Policy Number/Member ID includ er code. Example: XXH039682341 : :	ing any alphabetic prefix or 20747-0356497821-	*Last Name: *Birth Date: Relationship: *Address: *City:	Must be: MM/DD/YYYY Spouse, Self, etc.

- Enter your preferred email address, which we will use to contact you regarding the status of your insurance waiver.
- Enter your 10 digit preferred phone number. Please **do not** insert any dashes (-).
- Click on the magnifying glass to the right of the "Insurance Company list" field.

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Health Insur	ance Waiver Request	Waiver Status:	S - Submitted, /	A - Approved, R - Rejected, C - Cance
Student Information				
Name: Student ID:	Waiver ID:	DOB:	Format: XX	XXXXXXXX (Includes Area Code)
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Please provide the complete and numerical family membe 02.	Policy Number/Member ID inclu r code. Example: XXH03968234	iding any alphabetic prefix 11 or 20747-0356497821-	*Last Name:	Must be; MM/DD/YYYY
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• You will be presented with a list of Insurance Companies. Search for your insurance company by entering in the first few letters of the name at the top of the screen in the field that says "Insurance Company Name" and change the drop down arrow from "begins with" to "Contains", then select "Look Up". Simply click on the Insurance Company Name and in the insurance company name will automatically populate in your waiver.

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• If you can't locate your Insurance Company, search for "Other" and select that option. You will then need to enter the appropriate address information manually.



• Once your insurance company information has been entered, enter the "Subscriber Information" toward the right of the screen. This is the name, birth date, and relationship to you of the person whom the insurance policy is written for. This could be a parent, guardian, spouse or any other person whom carries you on their insurance. If you have your own insurance, simply enter your own name and birth date. To see a sample insurance card to help you with your waiver please <u>click here</u>.

*First Name:	
*Last Name:	
*Birth Date:	Must be: MM/DD/YYYY
*Relationship:	 Spouse, Self, etc.
*Address:	
*City:	
*State:	Y
*Zip:	
I do not want the U Plan. I certify that I indicated above, w year.	niversity Student Health Insurance have comparable coverage as hich will be in force for the academic
Lag	gree to the terms: 🔲

- Once you have completed filling out this information, read the terms of the waiver and place a check box in the box following "I agree to the terms:".
- Finally, click "**Submit Waiver**" in the lower right corner of the screen. A message will appear indicating your waiver has been submitted:

ng	Message
1	Your Health Insurance Waiver Request Has Been Submitted. (0,0)
	ОК

• You will receive a confirmation email at the address you specified in the waiver. Your waiver will be reviewed and approved/rejected within 30 days of submission. Please submit your waiver by the posted deadline to avoid purchasing the school sponsored health insurance.

Should you have any questions, please contact us at 401-874-4774.



United Healthcare:



Blue Cross Blue Shield:



<u>Aetna:</u>





Emblem Health:

EmblemHealth	Group Access Rx PPO
MEMBER: JOHN G. SAMPL ID NUMBER: 12345678900	EPLACEHOLDER
Network: GHI Medicare Choic CAT Code: KMG Copay: PCP 55 SPEC \$10 Rx \$0/\$00%/0% Preventive Dental: Preferred Network	e PPO <u>MedicareR</u> ER \$50 Rx BIN#: 013344 Rx PCN#: 0020080229 Issuer#: (80840) CMS#: H5528807

Kaiser Permanente:

ġ	Kaiser Permanente	•
		HAWAII REGION
	MEMBER ID NUMBER	
	LAST NAME, FIRST NAME, x MM DD YYYY GENDER BIRTHDATE	MI MED REGION

Premera BCBS:



<u>Tricare:</u>



DoD ID Number – a 10-digit number that is NOT used for TRICARE **DoD Benefits Number (DBN)** – an 11-digit number that may be used for TRICARE EDI claim submissions



CDPHP:



Neighborhood Health Plan:

Neighborhood Health Plan	
John A Sample NHP0000000 Maschealth 6	PCP/Specialist 50/0 Preventive Services 50 ER 50
RXBR: 004336 RXPCH: ADV RXCARX#24 RX1653	
NHP Connect	

Anthem BCBS:

BlueCross BlueShield		ney naranage	Expanded
JOHN Q. MEMBER			135.1
dentification Number <prefix><hcid></hcid></prefix>			CHOICE
Group Number BC/BS Plan	12345678 423/923	PCP/Specialist Copay Rx Copay	\$15/\$25
RX BIN PCN RX Group	003858 A4 WVEA	Tier 1/2/3	\$10/\$20/\$35

<u>Tufts:</u>

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TUFTS ASSOCIA	TED HEALTH P	INC	
MICHAEL SMITH	01 Group#	16100000	
Copayments	Office Visit	Specialist	
R: \$150	Tier 1: \$20	Tier 1: \$35	
Preventive: \$0	Tier 2: \$35	Tier 2: \$45	
	Tier 3: \$50	Tier 3: \$60	
Additional copaymen	ts & deductibles may apply	1.	
Member Services: (8	77) 658-3635		
Jurse Line: (866) 20	1-7919	BxBin: 00433	6
uffebealthelan com	C/	REMARK RXPCN: ADV	XTHP





Harvard Pilgrim:



Medical Claims: HPHC Claims Dept. P.O. Box 151288 Tampa, FL 33684 EDI Payer ID: 04245	Behavioral Claims: UBH P.O. Box 30760 Salt Lake City, UT 84130	Dental Claims: Dental Claims P.O. Box 30567 Salt Lake City, UT 84130
Men	ber Services: 888	-609-0692
TTY/TDD:	711 www.harva	rdpilgrim.org
Dental Customer Servi Behavioral Health: 000- Pharmacy Technical Supp Part D Prior Authorization	ce: 000-000-0000 Dental Prov 000-0000 Provider Services: (oof: 000-000-0000 on: 000-000-0000	iders: 000-000-0000 000-000-0000
Medimpact		Dental Benefit Providers

<u>Cigna:</u>



Coventry Health Care:

Health Care		FrU
MEMBER NAME: MEMBER NUMBE GROUP NUMBER	XXXXXXXMEMBERxNAN R: XXMBRXNBRX : XXGRPXNBRX	Exxxxxxx
PLAN: XXXXPLANX DATE OF BIRTH: MEMBER RESPONS PRIMARYOUTXX	TYPEXXXXX XX/XX/XXXX IBILITY: SPECIALTY SPX	DRUG:RXx
Please refer to your	Certificate of Covera	ge for coverage details.

Horizon Blue Cross

