AmeriHealth

STUDENT VERIFICATION FORM

DEL _____ NJ_____
HMO_____ PPO_____

PART I - MEMBER INFORMATION	*Please put responses on this column*
DEPENDENT NAME	
DEPENDENT MEMBER ID	
SUBSCRIBER NAME	
SUBSCRIBER SOCIAL SECURITY NUMBER	

PART II - DEPENDENT RELEASE	
I authorize the named school to release my enrollment status to AMERIHEALTH	
DEPENDENT SIGNATURE	
SIGNATURE DATE	

PART III - STUDENT VERIFICATION	*To be completed by the Registrar*
NAME OF SCHOOL	
CURRENT ENROLLMENT STATUS	
CURRENT TERM	
ATTEMPTED SEMESTER HOURS	
EXPECTED DATE OF COMPLETION	
IF GRADUATED, DATE DEGREE AWARDED	
REGISTRAR SIGNATURE Validate with School Stamp	
SIGNATURE DATE	

SUBSCRIBER'S SIGNATURE	
SIGNATURE DATE	
We verify that the above information is accurate and correct to the best of our knowledge.	

RETURN FORM WITHIN 30 DAYS TO:

AmeriHealth Enrollment Department
P.O. Box 42555
Philadelphia, PA 19101-2555