



STUDENT ACCIDENT REPORTING PROCEDURES INFORMATION SHEET

Dear Parents,

Your School Board continues to be vitally concerned about the health, safety and welfare of all students. We encourage safety, but we realize that sometimes student accidents do happen.

As a member of the Panhandle Area Educational Consortium-Risk Management program, the school board has purchased a student accident policy which covers all our students who are injured while in school or participating in school sponsored activities. **This insurance is accident coverage only and will not replace your current health insurance.** You need to continue such coverage for your protection.

This letter will serve as notice to you of a necessary change in the payment of expenses. We have experienced a significant increase in claims which has resulted in rising costs.

During the 2009-10 school year, **a deductible of \$100 shall be paid by the parent/guardian before any reimbursements are made from the insurance plan.**

In case of an accident, **you must file a claim with your own health insurance carrier first.** The School Board policy is designed to help pay for expenses which are not reimbursed by your health insurance and after your payment of the \$100 deductible is paid to the medical provider.

This policy provides coverage only for 730 days from the date of the documented related injury. The school district and hospital are not responsible for filing a student accident claim.

In the event of an accident, the following steps must be followed:

1. The student must report the accident to the designated school official and obtain a United Health Care, Health Special Risk, Inc., Claim Form. The top portion of the claim form is to be completed by a school representative and must be signed by a school official.
- 2. There are portions of the form that must be completed and signed by a parent/legal guardian. Forms will not be accepted if any signatures are missing.**
3. To assure timely processing of your claim, verify that all the questions on the form are answered. Attach itemized bills, paid receipts, explanations of benefits, and all relevant documents to the claim form.
4. If you have additional expenses after the initial claim is filed, submit the bills directly to United Health Care Student Resources and not to the school. Be sure to mail them within 90 days of the date of treatment.
5. Parents please keep a copy of all medical statements and billing notices for your records.

Give United Healthcare Student Resources a reasonable amount of time to process your child's claim. If you have not heard from the insurance company or continue to get repeat bills, check on the status of a claim by calling direct at (866) 409-5734 or write:

United Healthcare, Health Special Risk, Inc.
P.O. Box 117558
Dallas, TX 75011-7558



School District: _____

City and State: _____

School Name: _____

Policy Number: _____

STUDENT CLAIM FORM

- 1. Please fully complete this form
- 2. Attach itemized bills
- 3. Mail to HSR

E-mail : UHCSRclaims@hsri.com

P.O. Box 117558
 Carrollton, Texas 75011-7558
 Phone: (972) 512-5600 Fax: (972) 512-5818
 Toll Free (866) 409-5734

FOR **HSR** USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (injured/ill person)		2. Social Security Number		3. Gender <input type="checkbox"/> M <input type="checkbox"/> F		4. Date of Birth		5. E-Mail	
6. Address of Injured/Ill Person						7. Best Contact Phone Number (include area code)			
8. Parent/Legal Guardian Name, Address						9. Best Contact Phone Number (include area code)			
10. Date of Accident/Illness		11. Time of Accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		12. Place where Accident Occurred				13. Date of First Treatment	
Dental Claims	14. Indicate which Teeth were Involved in the Accident				15. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial				
16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)						Did Injury Result in Death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details									
18. Which Best Describes the Activity:									
<input type="checkbox"/> Not school related		<input type="checkbox"/> In school bus		<input type="checkbox"/> On school property during school hours		<input type="checkbox"/> School sponsored activity during school hours			
<input type="checkbox"/> P.E. class		<input type="checkbox"/> School sponsored field trip		<input type="checkbox"/> Traveling to/from school		<input type="checkbox"/> A spectator			
<input type="checkbox"/> During lunch hour		<input type="checkbox"/> Athletic period							
19. Name of Person Supervising the Activity					20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?				

REPORTS OF AT-SCHOOL OR ATHLETIC INJURIES MUST BE CERTIFIED BY A SCHOOL OFFICIAL

I hereby certify that the above named student was insured under the UnitedHealthcare StudentResources Plan at the time of the accident and I believe the accident occurred as stated herein.

Signature of Parent/Legal Guardian:	Signature of School Official:
X _____	X _____
Date:	Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? Yes No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant’s primary employer name, address, and phone number _____

If applicable, mother’s primary employer name, address, and phone number _____

If applicable, father’s primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian:	Signature of Witness:
X _____	X _____
Date:	Date:

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

FRAUD STATEMENTS

General: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.
Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to **HSR** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to **HSR** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. **HSR** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 7:00 a.m. thru 7:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

Health Special Risk, Inc.
P.O. Box 117558
Carrollton, TX 75011-7558