



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 2011-12 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 pay for reasonable 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 an Administrative Concepts, Inc Claim Form. The first part of the form will be completed by the school staff.
2. **The rest of this form must be completed by the parent/guardian and returned to Administrative Concepts, Inc. (ACI) within 30 days of the date you received medical treatment.**
3. If you have additional expenses after the initial claim is filed, submit the bills directly to ACI and not to the school. Be sure to mail them within 30 days of the date of treatment.
4. Parents please keep a copy of all medical statements and billing notices for your records.

Give ACI 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 ACI direct at 1-888-293-9229 or write:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802

ACCIDENT CLAIM FORM



**Gerber Life
Insurance Company**

MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com

For Customer Service, Call 888-293-9229 and Press "2".

Any person who knowingly presents a false or fraudulent claim for payment of 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.

PART A: SCHOOL AND PARENT

Policy No. 09-2656-11

- (1) School: Panhandle Area Educational Consortium (County Name Here) (2) School ID#: _____
(3) School Address: _____ (4) School Phone # _____
(5) Student: _____ (6) Student's Social Security# _____
(LAST NAME) (FIRST NAME)
Male
(7) Grade: _____ (8) Birthdate _____ (9) Female (10) Date of Injury _____ (11) Time _____
(12) Where did injury occur? _____ (13) Date of first treatment _____
(14) How did injury occur? _____
(15) Part of body injured _____ (16) Type of sport _____
(17) At the time of injury was the student involved in a school sponsored & supervised activity? Yes No
(18) If athletics, designate: P.E. Class Intramural Interscholastic Practice Game
(19) Under whose supervision? _____ Was he/she a witness? Yes No
(20) Signature: X _____ Title _____ Date _____
(must be signed by school official unless injury did not occur during school activity.)

Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

PART B: PARENT OR GUARDIAN STATEMENT

- (1) Student's Social Security # _____ (2) Date of first treatment _____
(3) Father's Name _____ Social Security # _____
(4) Mother's Name _____ Social Security # _____
(5) Home Address _____ (STREET) (CITY) (STATE) (ZIP) (HOME PHONE NO.)
(6) Father's Employer _____ Business Phone # _____
(7) Employer's Address _____
(8) Name and Address of other Insurance Company _____
(9) Policy No. _____ Group Individual Other No Other Insurance
(10) Mother's Employer _____ Business Phone # _____
(11) Employer's Address _____
(12) Name and Address of other Insurance Company _____
(13) Policy No. _____ Group Individual Other No Other Insurance

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

SIGN: Parent or Guardian: _____ Date _____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

STREET

CITY

STATE

ZIP CODE + 4

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

INSTRUCTIONS

1. PART A – must be completed by the school.
2. PART B – must be completed by Parent or Guardian.
3. **This plan of insurance is secondary to any health insurance you have. If you have any other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to ACI (at the address listed below). Attach all itemized medical bills (with diagnosis), you have received to date including this completed form. Later bills can be mailed to the insurance company separately. Please show name of school on all later bills. Please do not submit balance due, balance forward or past due statements for payment. Sending these types of statements will only delay payment, as ACI will need to request an itemized bill.**
4. Mail this report and bills within 30 days after the first treatment to:

Administrative Concepts, Inc
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802

Phone: 888-293-9229
Fax: 610-293-9299
Web: www.visit-aci.com

The laws of some states require us to furnish you with the following notices:

WARNING Any person who knowingly

Alaska: 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, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR and RI** 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana : and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

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

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (**or specific to LA, TX and W VA:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (**or specific to NM:** to civil fines and criminal penalties.)

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

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

Ohio: 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: 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: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING

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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine /Washington: 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.

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

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 RS! 638.20.

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