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 2008-09 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 Student Resources Student Claim Form. The top portion of the claim form is to be completed by the Parent/Guardian of the injured child.

2. **The bottom of the form must be signed by a school official. The form will not be considered if it is not signed by a school official.**

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 (888) 251-6160 or write:

United Healthcare Student Resources
P.O. Box 809027
Dallas, TX 75380-9027

Student Claim Form **United Healthcare Student Resources** **P.O. Box 809027** **Dallas, TX 75380-9027** **(888) 251-6160**	**School District: PAEC -** ____ **City and State:** ____ **School Name:** ____ **Policy Number: 2008- NOT YET ASSIGNED** __________________________

Student's Last Name__________________________________ **Student's First Name**___________________________ **Student's Nickname**_____________________ (If Applicable)

Date of Birth _________________________________ **Grade** ______________

Name of Parent/ Legal Guardian		Address Street/ PO Box			
City		State		Zip Code	

WHAT OTHER INSURANCE COMPANY/COMPANIES PROVIDE COVERAGE THAT WOULD COVER THIS CLAIM?

Name of Company(s)____ **Name of Insured** ____

If NO Other Insurance, Sign Here____

STATEMENT BELOW MUST BE SIGNED WHEN TREATMENT REQUIRES SURGERY OR HOSPITAL CONFINEMENT.

I hereby authorize the hospital or doctors involved to give UnitedHealthcare StudentResources all information regarding the insured's condition, including the history obtained, findings and diagnosis. A photocopy of this form shall be considered as valid as the original.

Date______________________________**Signature of Parent or Legal Guardian** ____

I authorize payment directly to my medical provider(s) for charges for this claim. I understand that I am financially responsible for all charges not covered by this authorization.

Date__________________________ **Signature of Parent or Legal Guardian**____

DESCRIBE ACCIDENT/ILLNESS IN DETAIL

Date of Injury_____________________ **Time of Injury** _______________( ) AM ( ) PM **Date of First Treatment**__________________

Place of Injury ____________________________________ **Name of Person Supervising the Activity** ________________________________

Which Best Describes the Activity:

( ) P.E Class
( ) During Lunch Hr
( ) Not School Related
( ) In School Bus
( ) Athletic Period
( ) School Sponsored Activity
( ) A Spectator
( ) School Sponsored Field Trip
( ) On School Property during during school hours
( ) Traveling to/from school

Describe how injury happened or the nature of an illness?____

____

If engaged in an Interscholastic Sport at the time of the injury, what was the sport?____

What part of the body was injured? ____

____

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.

Date_______________**Parent or Legal Gardian**_____________________________________**School Official**____________________________

TO ASSURE TIMELY PROCESSING OF YOUR CLAIM, PLEASE VERIFY ALL THE QUESTIONS ABOVE ARE ANSWERED. ATTACH ITEMIZED BILLS, PAID RECEIPTS, EXPLANATIONS OF BENEFITS, AND ALL RELEVANT DOCUMENTS TO THIS CLAIM FORM.

K12CLMFRM08

THE FOLLOWING NOTICE IS APPLICABLE TO ANY STATE NOT INDIVIDUALLY LISTED BELOW

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 MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL PENALTIES.

AK - 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.

AZ – 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.

AR - 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.

CA – For your protection California law requires the following to appear on this form. 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.

CO – 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.

DE – 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.

DC – 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.

FL - 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.

ID – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

IN – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY - 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.

LA - 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.

ME - 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.

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

NH – 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 RSA 638:20.

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

NM - 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.

NY - 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.

OH - 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.

OK - 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.

PA - 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.

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

TX – 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.

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

HOW TO FILE A CLAIM FORM

THIS CLAIM FORM MUST BE SENT WITHIN 90 DAYS OF THE DATE YOU FIRST RECEIVED MEDICAL CARE. IF YOU DID NOT SIGN THE REVERSE SIDE TO PAY BENEFITS TO PROVIDER, YOU MUST INCLUDE ORIGINAL RECEIPTS FOR EACH PAID BILL. KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

PLEASE FOLLOW THESE INSTRUCTIONS:

1. All lines must be completely filled out and be sure to sign the Medical Authorization.
2. Send **ORIGINAL ITEMIZED BILLS** with diagnosis and the corresponding **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**. (Keep copies for your records) **BALANCE FORWARD STATEMENTS ARE NOT SUFFICIENT.**
3. Mail completed form to: UnitedHealthcare **Student**Resources, P. O. Box 809027, Dallas, TX 75380-9027.
4. Attach itemized bill to completed claim form. An itemized bill must include:
   a. School District name
   b. Patient's name
   c. Patient's complete address
   d. Diagnosis
   e. Date of service(s)
   f. Description of treatment (i.e. type of x-ray, office visit, lab test, etc.). Including CPT (procedure) codes
   g. Doctor's/Hospital name, address and telephone number
5. Please do not send bills without a completed claim form. The bills will not be processed with partial information.