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)

3. Mail completed form to: Student Insurance, P. O. Box 809066, Dallas, TX 75380-9066

4. If you already paid the doctor or hospital, include a paid receipt and/or a copy of your cancelled check.

5. 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.)
   g. Doctor's/Hospital name, address and telephone number

6. If you have other bills, such as x-rays or laboratory charges, be sure to attach these original itemized bills and corresponding Explanation of Benefits Notice from your primary carrier to the claim form. Send your claim form and all of the itemized bills as directed on the reverse side of this form. Attach all of your bills for injury to the same claim form.

7. Please do not send bills without a completed claim form. The bills will not be processed with partial information.

FRAUDULENT CLAIM DISCLOSURE

Any incorrect, misleading or undisclosed information regarding other insurance coverage can result in duplicate payments creating a substantial overpayment. Any person who, knowingly and with intent to defraud, files a statement of claim containing materially false information or conceals information concerning any material fact, commits fraudulent insurance act, which is a federal offense. Any attempt to collect full primary benefits in excess of the total covered expenses under two or more group insurance plans is considered mail fraud and will fall under federal jurisdiction.

SUPPLEMENTAL STUDENT ACCIDENT CLAIM FORM

SEND YOUR CLAIM FORM TO:

Student Insurance
P. O. Box 809066
Dallas, TX 75380-9066
(800) 767-0700

SCHOOL INFORMATION

(1) School District	(2) School Site
(3) School Address	(4) School Phone Number
(5) At the Time of Injury, was the Student Involved in a School Sponsored & Supervised Activity? Yes ☐ No ☐	
(6) If Athletics, Designate PE Class ☐ Intramurals ☐ Interscholastic ☐ Practice ☐	
(7) Type of Sport	
(8) Under Whose Supervision?	(9) Was Accident Witnessed? Yes ☐ No ☐ (10) By Whom
(11) Signature: (Must be signed by school official) Title	Date

STUDENT INFORMATION

(12) Student Name (Last) (First) (Middle Initial)			(13) Social Security Number	
(14) Female ☐ Male ☐	(15) Birth Date	(16) Grade	(17) Time of Injury	(18) Date of Injury
(19) Where did Injury Occur?			(20) Date of First Treatment	(21) By Whom
(22) Part of Body Injured				
(23) How did Injury Occur?				

PARENT OR GUARDIAN INFORMATION

(24) Father's Name				
(26) Mother's Name				
(28) Home Address (Street)	(City)	(State)	(Zip)	(Phone Number)
(29) Father's Employer				(30) Employer's Phone Number
(31) Employer's Address				
(32) Name and Address of Insurance Referenced in #29 (must be completed)				
(33) Policy Number	Individual ☐	Group ☐	Other ☐	
(34) Mother's Employer				(35) Employer's Phone Number
(36) Employer's Address				
(37) Name and Address of Insurance Referenced in #34 (must be completed)				
(38) Policy Number	Individual ☐	Group ☐	Other ☐	

I hereby authorize any insurance company, hospital, physician, employer 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 coverages, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information thereto with the intent to defraud an insurance company.

(Date) (Signature of Responsible Party or Student if 18 years old)

AUTHORIZATION TO PAY BENEFITS PROVIDER: I hereby authorize payment directly to the Provider of Surgical and/or Medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

(Date) (Signature of Responsible Party or Student if 18 years old)

IMPORTANT NOTICE

This insurance is **excess** to all other valid and collectible insurance. If you have other medical insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills and this completed claim form. Please print or type. If this claim form is not completed in FULL, this claim form will not be processed and will be returned.