SCHOOL INSURANCE CLAIM FORM

CLAIM FORM AND NOTICE OF INJURY TO BE MAILED TO:
SCHOOL INSURANCE OF FLORIDA, P.O. BOX 784268, WINTER GARDEN, FLA. 34778-4268
The underwriting insurance company is Reliance Standard Life Insurance Co. Schaumburg, IL.

PARENTS: Policy limitations and exclusions are on the take home summary of insurance brochure. The Policy does not pay 100% of billed expense. It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This is ***'Excess Insurance***'. **Y**ou MUST file a claim with your primary insurance first. A school Official is required to fill out PART B only if the injury is school related. This form cannot be processed unless all questions are answered below and all signatures are in place. It is the duty of the claimant,(Parent/Legal Guardian), to furnish the company with itemized bills, explanation of primary insurance benefits paid, and this form completed. Visit School Insurance of Florida . Com for information regarding where to seek treatment and claim filing instructions. THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS AFTER DATE OF ACCIDENT. The policy allows for bills to be sent in for up to one year from the date of accident. **PLEASE DO NOT LEAVE THIS FORM WITH YOUR PHYSICIAN OR HOSPITAL.** It is the parent/guardian's responsibility to ask Doctors/ Providers what remaining balances you may be required to pay regarding this claim, if any.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A. Please print your answers.

1. Name of School: County: Grade:

2. Last Name of Student: First Name: Middle Initial:

3. Mailing Address of Parent: City: State: Zip:

4. Home Phone # ( ) - Date of Birth / /

5) **WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW, WHEN AND WHAT OCCURRED, THAT CAUSED THE INJURY. (Use back of this form if more space is needed).** How? What? When? Be specific please.

_____

_____

_____

6. **INJURY DATE:** Month_____Day_____Year_____Time_____ AM or PM - Where did the accident happen?_____

If this is sports related what is the name of the team or camp?_____

7. Nature of Injury or sickness (indicate part of body injured-such as broken arm, sprained ankle etc…) _____

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this line blank).
Other insurance includes but is not limited to the following: HMO's, PPO's BC/BS, United, Employer Benefits, ERISA, Medicaid, Welfare or Government Trust accounts, or Tri-care. **It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This policy will not pay for 100% of billed charges.** What is deductible or co-pay (if any)? $_____

If you have a Medicaid plan please send a copy of your insurance card with this form.

9. Address of claims office of insurance company on line 8._____

10. Mother's Name and Employer:_____Occupation:_____

Mother's Employer Address:_____Telephone #_____

11. Father's Name and Employer:_____Occupation:_____

Father's Employer Address:_____Telephone #_____

****The above answers are true and correct. I hereby authorize any person or institution to release any information requested by the insurance company or its agent to them, including history and physical, diagnosis or other medical or insurance information. A photo static copy of this authorization shall be considered as effective and valid as the original. **FLORIDA LAW:** "Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree."*

PARENT/
12. GUARDIAN SIGN HERE:_____ Today's Date:____/_____/_____Print Name: _____

PART B - Must be filled out and signed by a School Official for ALL school sports related injuries. Must be filled out for all other school related injuries unless the student purchased the 24 Hour Plan.

1. WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW THE ACCIDENT OCURRED THAT CAUSED THE INJURY. Please be specific. (Use back of this form if more space is needed.)

_____

_____

2. Injury Date: Month_____Day_____Year_____Time_____AM or PM Part of body injured (include whether right or left)_____

3. At the time of the injury was the student involved in a school sponsored, funded, scheduled and supervised activity? YES NO

Please select or list the interscholastic sport or activity the student was participating in. Circle One.
P.E. Class - Football Game - Football Practice - Soccer - Volleyball - Baseball - Softball - Track - Wrestling - Flag Football - Competitive Cheerleading - Rugby Lacrosse-- Side line Cheerleading - Basketball OTHER LIST _____

4. Under whose supervision(witness)?_____ What date has the Athlete returned to play if applicable? ____/____/_____

5.Print Name of School Official _____School phone Number:_____-_____-_____

6.**Original Signature of School Official** _____(Only if injury is School Related) Today's Date:____/_____/_____

Please DO NOT LEAVE THIS FORM with the Doctor or Hospital. Mail to School Insurance of Florida immediately upon completion.

PART C: ATTENDING PHYSICIAN OR DENTIST STATEMENT. Itemized bills are required to determine the eligibility of a claim. **If the provider is going to bill us directly you do NOT need to have PART C completed.**

1. Diagnosis and Concurrent conditions. Explain any complications._____

2. Date you first treated the sickness or injury____/____/_____ Dates of subsequent treatment: _____

3. When did the symptoms first appear? Date: _____

4. Were your services necessary solely because of the incident described in part A(front)? YES NO Is treatment completed? YES NO

5. Did any previous injury, sickness or impairment contribute to this injury? YES NO If yes, explain details._____

_____

6. Did x-ray show fracture? YES NO If fracture or dislocation, state whether reduced or immobilized and what the procedure was?

_____CPT/CRVS_____

7. Physician's Degree (M.D.,etc.)_____ Print name of physician or dentist: _____

8. Federal tax ID# (or Soc. Sec. #) _____ **(Benefits cannot be paid to you without this).**

9. Address of physician or dentist. STREET NUMBER_____

CITY_____STATE_____ZIP CODE_____ ***Signature of physician or dentist***: _____

10. FOR DENTAL CLAIMS ONLY: Indicate which teeth were involved in the accident? _____
11. Describe condition of injured teeth prior to accident: **Circle conditions:**
Filled--- Capped--- Artificial--- chipped--- broken--- crowned- damaged--- abscessed---Otherwise Fitted--- Whole, sound and natural--- Other_____

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

1) You must file your claim with your other (Primary) insurance company first. Other insurance include, but not limited to: HMO's, PPO's BC/BS, United, Employer Benefits, HSA's or Tri-care***. This is secondary coverage*** and may not pay for 100% of medical expenses incurred. When your claim has been processed by your primary insurance; mail a copy of the explanation of benefits (EOB's), the itemized bills to *School Insurance of Florida.* **We cannot accept a balance due statement, itemized bills are required.** ***Important note***: **Please do not leave the claim form with the Hospital or Doctor's Office.** Participants can seek treatment from any licensed provider of service. **It is the participants responsibility to find out what out of pocket expenses they could incur. Please ask your provider of service if they are in your primary network. Visit School Insurance of Florida .Com for provider information.**

2) **A completed School Insurance of Florida Claim Form must be submitted within *90 days* from the date of the incident**. If the condition is school related or happened at school Part B must be completed. If the condition did not happen at school complete Part A and mail directly to School Insurance of Florida. For additional information please contact School Insurance of Florida 1-800-432-6915.

3) The plan administrator mailing address is: **School Insurance of Florida**
P.O Box 784268
Winter Garden, FL. 34778-4268

Reasons claims are delayed for processing: **1**. Claim Forms Not Completed In Full or Not Submitted. **2**. Balance Due Statements, Balance Forward Statements, or Past Due Statements submitted instead of the correct Medical Itemized Bills (UB-04/92 or HCFA-1500) which are standard forms used by providers of service or Doctors. **3**. Explanation of Benefits from Primary Insurance Carrier not provided with the correct bills.

If we do not receive your reply within 45 days, we will close our file. However, upon receipt of the requested information, we will reopen the file and process your claim in accordance with the policy provisions.

ADDITIONAL
COMMENTS:_____

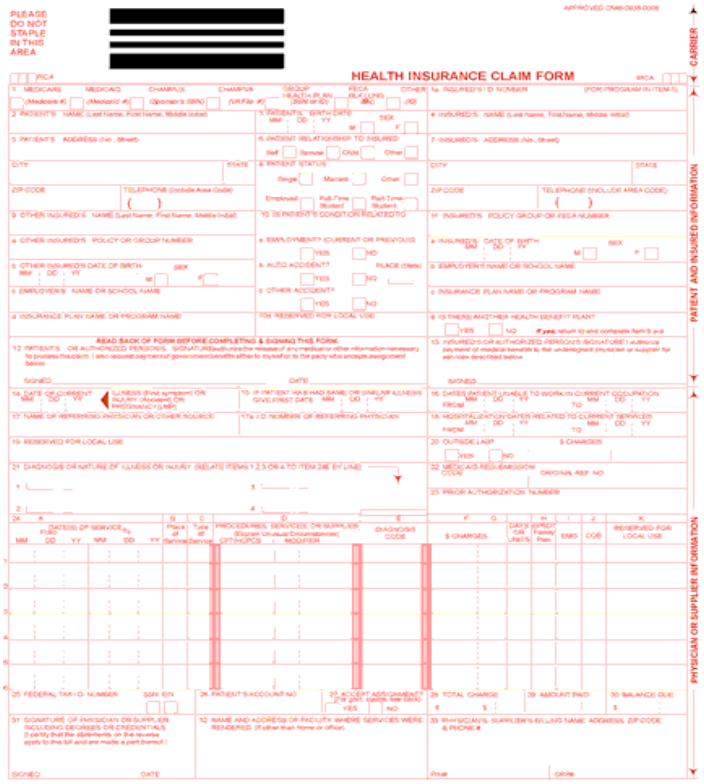
_____

_____

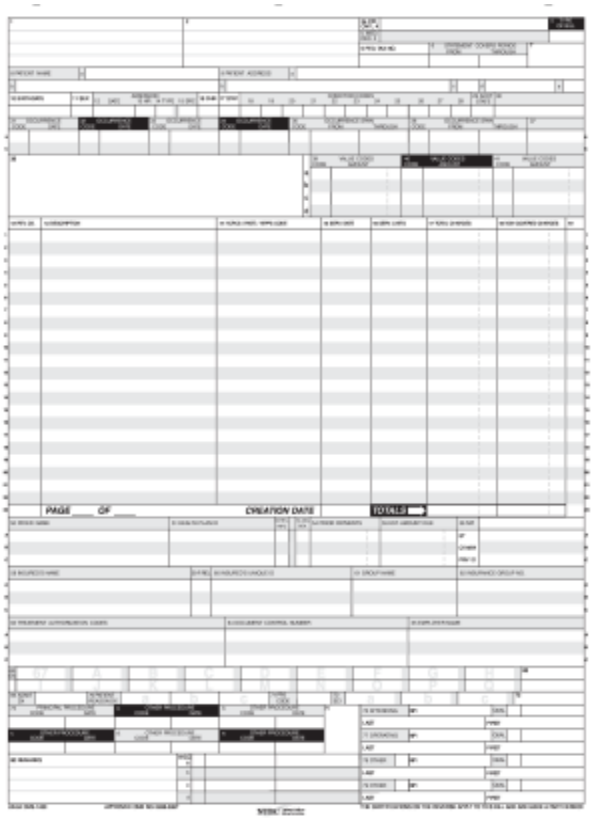
_____

This is a sample of an itemized bill. Balance due statements or summary of accounts are not itemized bills. Please submit itemized bills so we may promptly review claims.

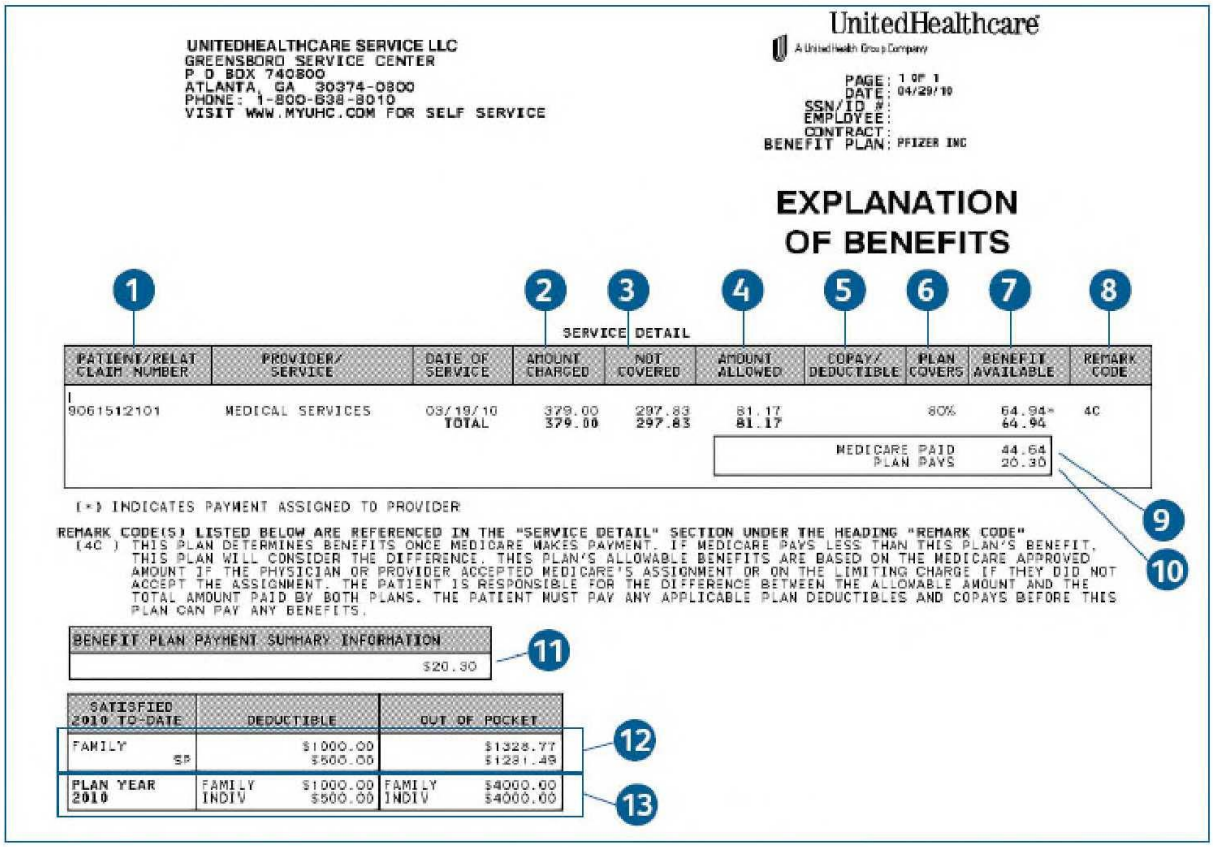
SAMPLE HCFA 1500



SAMPLE UB-04



SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
		TOTAL	379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE		OUT OF POCKET	
FAMILY	$1000.00		$1328.77	
SP	$500.00		$1281.48	
PLAN YEAR 2010	FAMILY INDIV	$1000.00 $500.00	FAMILY INDIV	$4000.00 $4000.00