2017-2018 K-12 ACCIDENT ONLY CLAIM FORM

MAIL TO: Catlin Insurance Company
27422 Portola Pkwy, Suite 110
Foothill Ranch, CA 92610
Phone (844)-882-8318 / Fax (949)-271-2330

Account Management:
469-579-4139 Main
469-579-4482 Fax

CLAIM INSTRUCTIONS

- The accident form must be submitted within 90 days from the date of injury to Student Insurance Plans ***BY THE PARENT OR GUARDIAN***
  DO NOT WAIT FOR BILLS TO SUBMIT THE ACCIDENT FORM. DO NOT EXPECT THE PROVIDER TO FILE THIS FOR YOU.
- Treatment must commence within 90 days of injury. Treatment will be covered for 1 year from accident date.
- All payments will be made to the providers of service (Hospital, Physician and others), unless accompanied by a paid receipt.
- Mail all ITEMIZED bills showing diagnosis, dates of treatment and charges to Student Insurance Plans with any applicable Explanation of Benefits from the primary insurance carrier **within 90 days of treatment or payment by the primary insurance carrier**
- Full Excess coverage - **benefits are payable for covered expenses that are not payable by another Health Care Plan**

FAILURE TO FOLLOW PRIMARY CARRIER'S GUIDELINES WILL RESULT IN DENIAL OF BENEFITS

- Please note the name of the school DISTRICT on all bills and correspondence. NO ADDITIONAL CLAIM FORM IS NECESSARY.

For Verification of provider participation visit imsppo.com

NO CLAIM CAN BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

PART I - SCHOOL REPORT

1. School District	2. Name of School			
3. Student Name: Last First Middle	4. Students ID#	5. Grade	6. Birthdate	7. Sex

8. Nature of Injury (Please describe fully indicating what part of the body was injured – i.e. broken arm, sprained ankle, etc.) Left ☐ Right ☐

9. Describe how accident occurred. (Give all possible details.) ***MUST BE A BODILY INJURY DUE TO AN ACCIDENT.***

10. If accident occurred at school or school sponsored activity, please complete the following:	11. a) Date & Time of Accident	12. Name/Type of Activity
Yes☐ No☐ a) While claimant was supervised?	b) Place Occurred:	
Yes☐ No☐ b) During a sponsored activity?		
13. Name and Title of School Official	14. Signature of School Official	15. Date

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

OTHER INFORMATION--MUST BE COMPLETED IN FULL

1. Name of Father or Guardian:	
2. Name of Mother or Guardian:	
3. Home Address:	3A. Home Phone Number:
(City, State, Zip Code)	
4. Name and Address of Father's Employer:	4A. Phone Number:
5. Name and Address of Mother's Employer:	5A. Phone Number:

6. Is the student covered under any other insurance? Yes ☐ No ☐ Group or Individual?
If the coverage is Group, please provide the following information:
Name of Insured: _____ Relationship to Student: _____
Insurance Company: _____ Phone # or Policy #: _____
7. Is the student insured under CHIPS or Medicaid? Yes ☐ No ☐

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 US Mail may be fraudulent and violate federal laws, as well as State laws** I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

_____ _____

Signature of Parent or Guardian **MUST BE SIGNED** Date Signed

FORM ON SECOND PAGE MUST ALSO BE COMPLETED

Catlin Insurance Company
27422 Portola Pkwy, Suite 110
Foothill Ranch, CA 92610
(844)-882-8318

STUDENT NAME: _____

SCHOOL DISTRICT: _____

We have received charges for services rendered to the above referenced student, however in order to process this claim we need verification regarding other insurance coverage.

Is the student covered under any other insurance coverage?

☐ Yes ☐ No

If yes, is this coverage(s) a group or individual policy? _____

If coverage(s) is a group policy, please provide the following information:

Name of the Insured: _____

Relationship to student/patient: _____

Insurance Company: _____

Affidavit: I verify that the above statement regarding other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent/Guardian Date

PLEASE NOTE: Coverage is provided on an excess basis. No benefit of this policy is payable for any expense which is paid or payable by other valid and collectible insurance including any ERISA or self-funded group plan or automobile insurance. If other insurance coverage is applicable, file your claim with them first. When you receive the explanation of benefit/denial (EOB) from your other insurance, send it to the above address along with itemized bills.
Benefits for eligible expenses will be paid per policy terms.