SUPPLEMENT TO MEDICAL EXPENSE CERTIFICATE

TO BE COMPLETED BY INJURED PARTY OR, IF A MINOR, BY THE MINOR'S PARENT OR GUARDIAN

NOTICE TO INJURED PARTY OR PARENT/LEGAL GUARDIAN: This supplement form to your original Medical Expense Certificate must be submitted to the Member School District within fourteen (14) months of the occurrence with all requested documentation, including Attachment A, related to treatment received within one year of the occurrence. The date submitted to the school district is considered the date submitted to NCSBT for purposes of the 14-month deadline. Failure to provide complete information will affect recovery of benefits. You must sign your fully completed form in the presence of a notary public and submit it to the Superintendent or the Superintendent's designee. THIS FORM SHOULD ONLY BE USED TO PROVIDE ADDITIONAL INFORMATION/DOCUMENTATION TO SUPPLEMENT A MEDICAL EXPENSE CERTIFICATE WHICH YOU HAVE PREVIOUSLY COMPLETED AND PROVIDED TO THE SUPERINTENDENT OR HIS OR HER DESIGNEE REGARDING AN ACCIDENTAL INJURY.

The Superintendent or designee must sign the completed form upon receipt and forward it to the North Carolina School Boards Trust ("NCSBT"). ***See additional instructions on page 6.***

Occurrence/Injury Information

1) Injured party's name: First ____________________ Middle _________________ Last ____________________
2) If injured party is a minor, name of parent or legal guardian: ____
3) Date of occurrence: ____
4) School where occurrence happened: ____

   School District where occurrence happened: ____
5) Is treatment complete? ☐ Yes ☐ No

Insurance/Benefits Information

6) Is the injured person covered under health or medical insurance coverage? ☐ Yes ☐ No

   If yes: Name and address of health or medical coverage insurance company: ______________________________

   ____

   Phone: ____

   Name of Insured/Covered Person: ____

   Policy Number: ___________________________ Group Number: ______________________________

   Plan Number: ____

7) Is the injured person covered under dental insurance coverage? ☐ Yes ☐ No

   If yes: Name and address of dental coverage insurance company: _________________________________

   ____

   Phone: ____

   Name of Insured/Covered Person: ____

   Policy Number: ______________________________ Group Number: ___________________________

   Plan Number: ____

8) Is the injured person eligible for the following?

   Medicaid ☐ Yes ☐ No Medicare ☐ Yes ☐ No If yes, HICN or MBI ____________________

   Other Government Medical Assistance Benefits: ☐ Yes ☐ No

   If yes, identify: ______________________________________

9) Is the injured person a student enrolled in the Member School District? ☐ Yes ☐ No

If yes, is the injured person covered under any student accident and/or athletic coverage purchased by the parent or guardian through the Member School District? ☐ Yes ☐ No

If yes: Name and address of insurance company: ______________________________

____

Phone: ______________________________

Policy Number: ______________________________

Coverage Limit For Covered Claims

The coverage limit for covered claims is $2,500 per person*/coverage period, subject to the Member School District's per occurrence limit and coverage period aggregate. *(For accidental injury occurring on or after July 1, 2024, a $1,000 dental sublimit applies.) Claims for which the combined Medical Expense Certificate and Supplement to Medical Expense Certificate seek reimbursement/payment in excess of the applicable coverage limit will not be considered until revised and resubmitted within the applicable coverage limit.

Excess Coverage

This coverage is excess over any other benefits available for the Accidental Injury, including but not limited to the injured party's health insurance (with the exception of Medicare) and any student accident and/or athletic coverage. No benefits will be paid under this program in circumstances where other insurance/coverage is applicable and/or pending.

Required Medical Documentation

This section of the Supplement to Medical Expense Certificate must be fully completed in order for your claim to be considered. Any corrections or additional information necessary to cure an incomplete Supplement to Medical Expense Certificate must be submitted to NCSBT within two months of the expiration of the deadline to timely submit a Supplement form.

Provide all information required below regarding all medical expenses for which you are seeking reimbursement/ payment (*i.e.,* expenses not covered under the insurance, plans, or benefits programs identified above). **You must provide current updated, itemized medical provider statements which reflect date(s) of service, services rendered, International Classification of Diseases diagnostic codes (ICD-10 diagnostic codes), charges for services, payments, and any outstanding balances.** You must also provide all applicable Explanation of Benefit statements. If additional space is needed, please list on a separate page and attach. "See attached" is not an acceptable response to this section:

- Provider Name: ______________________________

  Date(s) of Service: ______________________________

  Medical Services Rendered: ______________________________

  Original Amount of Bill: $____________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $______________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $______________

- Provider Name: ______________________________

  Date(s) of Service: ______________________________

  Medical Services Rendered: ______________________________

  Original Amount of Bill: $____________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $______________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $______________

- Provider Name: ____
  Date(s) of Service: ____
  Medical Services Rendered: ____
  Original Amount of Bill: $___________
  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________
  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

- Provider Name: ____
  Date(s) of Service: ____
  Medical Services Rendered: ____
  Original Amount of Bill: $___________
  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________
  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

I, ______________________, hereby certify that the information provided on this Supplement to Medical Expense Certificate and the attached documentation represent all true, correct, current, and up-to-date information supporting my claim, and I have completed this form and provided such documentation to the best of my ability.

This the _______ day of ___________________, 20_____.

This form must be signed by the injured party or, if the injured party is a minor, by the injured party's parent or guardian. Forms that are signed by anyone other than the injured party or, if appropriate, the injured party's parent or guardian will be returned for the required signature.

____
Signature

____
Print Name

NORTH CAROLINA
COUNTY OF _______________

I, ______________________, a Notary Public of the County and State aforesaid, do certify that _________________________ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this the _______ day of ___________________, 20_____.

____
Notary Public

____
Print Name

My Commission Expires: ________________

PLEASE COMPLETE PAGE 5, SUPPLEMENT TO MEDICAL EXPENSE CERTIFICATE DELIVERY CERTIFICATION, TO CONFIRM DELIVERY OF YOUR SUPPLEMENT TO MEDICAL EXPENSE CERTIFICATE.

SUPPLEMENT TO MEDICAL EXPENSE CERTIFICATE DELIVERY CERTIFICATION

Please note that the injured party (or his or her parent/guardian) is responsible for ensuring timely submission of a completed Supplement to Medical Expense Certificate. Your complete Supplement to Medical Expense Certificate *must be submitted to the school district within 14 months of the occurrence* that caused the accidental injury. Failure to timely submit a Supplement to Medical Expense Certificate will result in denial of your claim.

Please certify below that you have delivered your completed Supplement to Medical Expense Certificate to the school district, including the method and date of delivery.

Method of Delivery	Date of Delivery
☐ Hand delivered to ________________________________	______________________
☐ Sent via email to ________________________________	______________________
☐ Faxed to ____	______________________
☐ Sent via registered mail to __________________________________	______________________

____

Signature of injured party or person certifying delivery

For your protection, especially for Supplements being submitted close to the 14-month deadline, you should retain a copy of the documentation that confirms the date the completed Supplement to Medical Expense Certificate was delivered to the school district (e.g., the email, fax confirmation, or mail return receipt).

For hand delivery, please ask the school district employee to whom the Medical Expense Certificate is delivered to sign below.

CONFIRMATION OF HAND DELIVERY

The signature below confirms that the Supplement to Medical Expense Certificate for ______________________________________ (name of injured party) was hand-delivered on ______________________ (date).

The signature below does not confirm that the Supplement to Medical Expense Certificate is completed fully or accurately, nor does it confirm that the claim will be covered under the terms of the Board's medical expense coverage.

____

Signature of school district employee accepting the Supplement to Medical Expense Certificate

____

School district employee's title

This form must be submitted by the school district to NCSBT.

TO BE COMPLETED BY THE MEMBER SCHOOL DISTRICT:

____
Signature of Superintendent or Designee

____
Print Name

____
Title

____
Date

THE FOLLOWING ITEMS MUST BE SUBMITTED TO NCSBT:

- Fully completed and executed Supplement to Medical Expense Certificate
- Attachment A
- Itemized, updated medical documentation to support each and every claimed amount
- A completed Supplement to Medical Expense Certificate Delivery Certification

Submit all of the above to the attention of Melody Coons at claims@ncsba.org.

If you have any questions, contact Melody Coons at mcoons@ncsba.org or 919-747-6684.

<u>**ATTACHMENT A**</u>

HIPAA Privacy Authorization Form

(Authorization for the use or disclosure of protected health information, required by the Health Insurance Portability and Accountability Act, 45 C.F.R. §§ 160, 164.)

I,______________________________________, on behalf of ______________________________________ ("Patient"), authorize Patient's healthcare providers to use and disclose the protected health information described below to the North Carolina School Boards Trust. This authorization for release of information covers all past, present, and future periods.

I authorize the release of Patient's complete health record: **(Circle A or B.)**

A. including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug or alcohol abuse; OR
B. with the exception of the following information: (Circle one or more of the following options.)
    a. Mental health records.
    b. Communicable diseases, including HIV and AIDS.
    c. Alcohol/drug abuse treatment.
    d. Other (please specify): ____.

The North Carolina School Boards Trust may use this medical information for billing or claims payment or other purposes as I may direct. This authorization shall be in force and effect until one year from the date of signing, at which time this authorization expires. I understand that I may refuse to sign this authorization and that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent any person or entity has already acted in reliance on my authorization. I understand Patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand information used or disclosed pursuant to this authorization may be disclosed by the North Carolina School Boards Trust and may no longer be protected by federal or state law.

____
Signature of Patient or personal representative

____
Printed name of Patient or personal representative and his or her relationship to the patient

____
Date

Clear All Fields