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# 학생 사고 및 질병 보험보험금 청구 안내

**부모/법적 후견인 용(또는 성인 학생용)**

## 보장 약관

상해나 질병이 발생하기 이전에 또는 이후 가능한 빠른 시간 내에, 보장 대상 활동들, 혜택, 예외, 요건 및 제한, 중요한 마감시간 등 보장 약관에 대해 숙지하십시오. 이들은 학교 당국에 제출한 보험증서, 보장을 받을 때 사용한 인쇄된 소책자, 온라인에서 보시거나 (800) 827-4695로 당사에 직접 연락하실 수도 있습니다.

## 보험금 청구 양식 및 보고

학교 관련 상해를 즉시 학교 당국에 가능한 한 자세하게 보고합니다.

학교에 학생 사고 및 질병 보험 보험금 청구 양식을 요청하고, 위임받은 학교 당국자에게 양식의 파트 A를 완전하고 읽을 수 있게 작성해 달라고 요청합니다. 보고 대상 상해가 학교 활동과 관련된 것이 아니라면, 귀하 자신이 파트 A를 작성할 수도 있습니다. 상해 또는 질병 당 하나의 보험금 청구 양식만이 필요합니다.

파트 B를 완전하고 읽을 수 있게 작성하고, 명시된 곳에 서명을 하고, 날짜를 적은 다음, 항목별 청구서(itemized bill) 및 다른 관련 보험 또는 건강 플랜으로부터의 혜택 설명서(Explanations of Benefits, EOB)와 함께 당사 사무실로 보내 주십시오.

**참고:** 다음 페이지에 있는 보험금 청구 양식은 영어로 작성해야 합니다. 도움이 필요하시면 당사 사무실에 연락하십시오.

## 의료 서비스 제공자 찾기

귀하의 자녀를 일체의 적절히 인가된 의료 서비스 제공자에게 데리고 갈 수 있습니다. 그러나, *First Health Network* 또는 *First Choice Health Network*(워싱턴주만 해당)와 계약된 제공자에게 치료를 받으면 본인 부담 비용을 줄일 수 있습니다. 계약된 의료 서비스 제공자는 www.firsthealth.com (800) 226-5116 또는 www.fchn.com (800) 231-6935에서 찾으실 수 있습니다. 귀하의 자녀가 HMO를 통해 치료받는 경우, 귀하의 HMO가 사전 승인하지 않은 네트워크 외부(out-of-network)의 서비스를 받는 경우 다수의 학교 지급 포괄적 플랜에 따른 혜택이 감소될 수 있습니다. 이 잠재적인 혜택 제한은 개인적으로 구매한 플랜에는 적용되지 않으며, 응급 치료에는 적용되지 않습니다.

## 치료를 받을 때

서비스 제공자의 수납/접수 담당자에게 귀하의 (해당 시) 일차 보험/건강 플랜 정보를 제공하십시오.

귀하의 자녀를 위해 당사의 개인 플랜을 구매하신 경우, 학생 보험 ID 카드를 제시합니다. 귀하의 자녀가 학교에서 지불한 포괄적 플랜의 보장을 받는 경우, 수납 담당자에게 이를 알리고 학교/학구를 명시합니다. 어떤 경우이든, 귀하의 자녀의 보장은 "2차 사고 의료 경비 보험" 또는 사고 및 질병 보험이며 종종 "제3자" 보험이라 불리는 것은 '아닙니다'. 귀하의 자녀는 피보험자입니다.

수납 담당자에게 Myers-Stevens & Toohey를 지불인으로 추가하고, 위에서 설명한 항목별 청구서를 당사로 직접 보내거나 (직접 보내는 것을 선호!) 당사에 전달할 수 있도록 귀하에게 동일한 청구명세서를 보내도록 요청합니다. 귀하가 보험 혜택을 서비스 제공자에게 지정한 것을 그들이 알게 함으로써 절차를 매끈하게 할 수 있습니다. 어려움이 있다면, 저희에게 연락하십시오. 즐거이 도와드리겠습니다.

## 귀하의 자녀가 다른 보험 또는 건강 보험을 가지고 있는 경우

일차 플랜(Medicaid는 예외)에 보험금을 청구하고, 처리 후 당사에 "혜택 설명서" 또는 "EOB" 사본을 보냅니다.

## 귀하의 자녀를 치료한 서비스 제공자로부터 당사가 필요로 하는 것

귀하의 보험금 청구를 평가하고 혜택을 제공하기 위해 일체의 서비스 제공자로부터 받은 상세한 항목별 청구서가 필요합니다. 이들은 의사 등의 서비스 제공자가 제공하는 HCFA 1500 또는 CMS 1500 양식 그리고 병원이나 수술 센터 등의 시설들이 제공하는 UB04 양식입니다. 그들은 다음의 필수 정보를 포함하고 있습니다:

- 서비스 날짜
- 청구 비용
- 진단 코드 - 이들은 귀하의 자녀들에게 어떤 문제가 있는지를 보여 줍니다
- 시술 또는 수익 코드 - 이는 문제를 평가/치료하기 위해 무엇을 하였나를 보여 줍니다
- 제공자 납세 ID 번호 - 혜택을 서비스 제공자에게 지정할 때 W-9 양식을 발행하기 위해 필요
- NPI(국가 제공자 식별자) - 연방 규정을 준수하기 위해 필요

***참고 -*** 당사는 위에서 설명한 필수 항목별 청구서 대신에 서비스 제공자로부터의 "명세서", 일차 건강 플랜 EOB 또는 지급 영수증을 사용할 수 없습니다.

**Kaiser 보험을 가지고 계신 경우, Kaiser 회원 서비스에게 "우대 명세서"(courtesy statement)를 요청하십시오. 이는 위에서 나열한 정보들을 포함하고 있습니다. 제출된 문서가 (있는 경우) 귀하의 자가 부담금이 얼마인지를 표시하도록 하십시오.*

## 최종 단계

다음 문서들을 다음 주소로 우송합니다: 1) 작성 완료한 보험금 청구 양식, 2) 항목별 청구서, 3) 기타 보험/건강 플랜 EOB (해당 시)

**MYERS-STEVENS & TOOHEY**
**Attn: Claims Department**
**26101 Marguerite Parkway**
**Mission Viejo, CA. 92692**

*또는* **팩스: (949) 348-9350** *또는* *이메일*: **claims@myers-stevens.com**

***추가 도움이 필요하십니까? (800) 827-4695 로 전화하십시오***

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# STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

## PART A SCHOOL/PARISH STATEMENT

(Parent or legal guardian may complete Part A if injury is not school/parish-related)

NAME OF CLAIMANT FIRST MI LAST | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO DAY YR

ADDRESS OF CLAIMANT CITY STATE ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____ | ID # FROM ID CARD (If applicable)

NAME OF SCHOOL/PARISH | NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM

SCHOOL/PARISH MAILING ADDRESS CITY STATE ZIP CODE | SCHOOL CONTACT EMAIL ADDRESS

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP ☐ RELIGIOUS EDUCATION ☐ CONFIRMATION ☐ YOUTH MINISTRY ☐ YOUNG ADULT MINISTRY ☐ CYO ☐ PAL ☐ OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION: | TYPE OF SPORT: | DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO If YES, name of plan:

DATE OF INJURY/SICKNESS | TIME OF INJURY A◯/◯. (Circle One) | WHAT **PART** AND/OR **AREA** OF THE BODY WAS INJURED? (Additional details may be provided below) ☐ RIGHT _____ ☐ LEFT _____ | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL/PARISH WAS NOTIFIED

NAME AND TITLE OF OFFICIAL COMPLETING FORM | SIGNATURE X | DATE SIGNED | SCHOOL/PARISH TELEPHONE NUMBER

## PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
IF YES, NAME OF PLAN(S) | POLICY NUMBER(S) | **IS THE CLAIMANT A MEDICARE BENEFICIARY?** ☐ **YES** ☐ **NO**

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER

**NAME OF FATHER OR LEGAL MALE GUARDIAN** | EMAIL ADDRESS | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

**NAME OF MOTHER OR LEGAL FEMALE GUARDIAN** | EMAIL ADDRESS | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

***AUTHORIZATION:*** I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

***ASSIGNMENT OF BENEFITS:*** I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

***FRAUD WARNING:*** Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

# STATE-SPECIFIC FRAUD WARNINGS

***Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

***Alaska:*** 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.

***Arizona:*** 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.

***Arkansas, Louisiana, Rhode Island, West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment for 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.

***California:*** For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

***Colorado:*** 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 within the department of regulatory agencies.

***Delaware:*** 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.

***District of Columbia:*** 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.

***Florida:*** 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.

***Hawaii:*** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

***Idaho:*** 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.

***Indiana:*** Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

***Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

***Maine, Tennessee, Virginia, Washington:*** it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

***Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

***New Hampshire:*** 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 R.S.A. 638.20.

***New Jersey:*** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

***New Mexico:*** 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.

***New York:*** 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 $5,000 and the stated value of the claim for each violation.

***Ohio:*** 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.

***Oklahoma:*** 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.

***Pennsylvania:*** 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.

***Texas:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Underwritten by: ACE *American Insurance Company* (Federal Insurance Company in New Mexico)

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