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Student Accident & Sickness Insurance
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)

Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. Coverage summaries may be obtained from school/parish authorities, printed brochures used to secure coverage, online, or by contacting us directly at (800) 827-4695.

Claim form and reporting

Report school/parish related injuries immediately to school officials, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized school/parish official to ***completely and clearly*** fill out Part A of the form. If the reported injury is not school/parish-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.

Completely and clearly fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.myfirsthealth.com (800) 226-5116 or (in the State of Washington only) www.fchn.com (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school/parish-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.

When treatment is sought

- Give the provider's billing/admissions department your primary insurance/health plan information (if applicable).
- If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school/parish, let the billing department know that and identify the district, Diocese or other school system involved and the specific school/parish. In either case, explain that your child has medical expense insurance that provides benefits on an excess or secondary basis and that it is NOT what is sometimes referred to as "third party" insurance. The student is the insured.
- Request the billing department to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

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

OR **Fax: (949) 348-9350** *OR* **Email: claimsinfo@myers-stevens.com**

Need more help? Call us at (800) 827-4695

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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.M. / P.M. (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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26101 Marguerite Parkway, Mission Viejo, CA 92692-3203
Office (800) 827-4695 • Fax (949) 348-9350 • claims@myers-stevens.com
CA License #0425842

CHUBB

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

First Health

First Choice Health

PPO Network - ***WA***

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Seguro de enfermedades y accidentes para estudiantes
INSTRUCCIONES PARA PRESENTAR RECLAMOS
PARA PADRES/TUTORES LEGALES (o estudiantes de edad legal)

Términos y condiciones de cobertura

Antes de que ocurra una lesión o enfermedad o tan pronto como sea posible posteriormente, familiarícese con los términos y condiciones de la cobertura, los cuales incluyen: qué actividades están cubiertas; beneficios; exclusiones; requisitos y limitaciones; fechas límite importantes, etc. Puede encontrarlos en las pólizas que se encuentran en los archivos de las autoridades escolares, en folletos impresos que se usan para asegurar la cobertura, en línea o poniéndose en contacto con nosotros directamente al (800) 827-4695.

Formulario de reclamos e informe

Informe inmediatamente al personal escolar sobre lesiones relacionadas con la escuela proporcionando la mayor cantidad de detalles que sea posible.

Solicite a la escuela un formulario de reclamo de Seguro de enfermedades y accidentes para estudiantes y pídale a una autoridad competente de la escuela que llene la Parte A del formulario DE MANERA COMPLETA Y LEGIBLE. Si le lesión que va a informar no está relacionada con la escuela, puede llenar usted mismo la Parte A. Solo se requiere un formulario de reclamo por lesión o enfermedad.

Llene DE MANERA COMPLETA Y LEGIBLE la Parte B (los campos faltantes causarán demoras), proporcione las firmas donde se soliciten, escriba la fecha y entréguelo a nuestra oficina junto con sus facturas detalladas y las Explicaciones de beneficios (Explanations of Benefits, EOB) de cualquier otro plan de seguro o plan de salud aplicable.

TÉNGALO EN CUENTA: El formulario de reclamo que se encuentra en la próxima página debe completarse en inglés. Llame a nuestra oficina si necesita ayuda.

Encontrar un proveedor de atención médica

Usted tiene la libertad de llevar a su hijo a cualquier proveedor de salud autorizado adecuadamente pero los gastos directos pueden reducirse si se hace atender con proveedores contratados de *First Health Network* o *First Choice Health Network* (solo WA). Puede encontrar proveedores contratados en www.firsthealth.com (800) 226-5116 o en www.fchn.com (800) 231-6935. Si su hijo también tiene cobertura a través de una Organización para el Mantenimiento de la Salud (Health Maintenance Organization, HMO) sepa que los beneficios de muchos de nuestros planes generales pagados por la escuela pueden reducirse si usted busca servicios fuera de la red que no estén autorizados previamente por su HMO. Esta limitación potencial de beneficios no se aplica a ninguno de nuestros planes adquiridos individualmente y no se aplica a la atención de emergencia.

Cuando pida atención

Proporcione a la persona encargada de la facturación/admisión del proveedor la información de su seguro médico principal (si corresponde).

Si usted adquirió uno de nuestros planes individuales para su hijo, presente su tarjeta de identificación de seguro estudiantil. Si su hijo está cubierto por un plan general pagado por la escuela, hágaselo saber a la persona encargada de la facturación e identifique la escuela o el distrito escolar. En cualquier caso, explique que la cobertura de su hijo es un "seguro secundario de gastos médicos por accidente" o un seguro de accidente y enfermedad y que NO es lo que a veces se denomina un seguro de "terceros". Su hijo es el asegurado.
Pídale a la persona encargada de facturación que añada a Myers-Stevens & Toohey a su sistema como pagador y que directamente nos envíe (¡preferiblemente!) las facturas detalladas que se describieron anteriormente o que le envíe las mismas facturas para que nos las reenvíe a nosotros. Informarle al proveedor que le está asignando beneficios puede ayudar a facilitar el proceso. Si tiene problemas, comuníquese con nosotros y con gusto lo ayudaremos.

Si su hijo tiene otro seguro o cobertura de salud

Presente un reclamo ante ese plan primario (excepto Medicaid) y envíenos copias de su "Explicación de beneficios" o "EOB (Explanation of Benefits)" una vez procesado.

Qué necesitamos de parte de los proveedores que atienden a su hijo*

Con el fin de evaluar su reclamo y proporcionarle beneficios, necesitaremos facturas completamente detalladas de cualquier proveedor que lo haya atendido. Estos formularios son el HCFA 1500 o el CMS 1500 si son de proveedores tales como médicos y el formulario UB04 de instalaciones tales como hospitales y centros quirúrgicos. Contienen la siguiente información requerida:

- Fecha(s) de servicio
- Cargos facturados
- Códigos de diagnóstico: informan qué problema tiene su hijo
- Códigos de procedimiento o ingresos: nos informan qué se hizo para evaluar o tratar el problema
- Número de identificación fiscal del proveedor: necesario para emitir los formularios W-9 cuando se asignan beneficios a proveedores
- Identificador de proveedor nacional (National Provider Identifier, NPI): necesario para cumplir con las regulaciones federales

NOTA: No podemos recibir "resúmenes" de parte de proveedores, Explicaciones de beneficios del plan de salud primario ni recibos de pago en lugar de las facturas detalladas requeridas según se describió anteriormente.

**Si usted tiene Kaiser, solicite "resúmenes de cortesía" de los Servicios para Miembros de Kaiser que incluyan la información mencionada anteriormente. Asegúrese de que la documentación presentada indique qué parte de los cargos, si los hubiere, está obligado a pagar de su propio bolsillo.*

Pasos finales

Envíe: 1) Formulario de reclamo completo; 2) Facturas detalladas; 3) EOB de otro seguro o plan de salud (cuando corresponda) a:

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

Fax: (949) 348-9350

Correo electrónico: claimsinfo@myers-stevens.com

¿Necesita más ayuda? Llámenos al (800) 827-4695

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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.M. / P.M. (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 _____

ADVERTENCIAS DE FRAUDE ESPECÍFICAS DEL ESTADO

Alabama: Cualquier persona que a sabiendas presente un reclamo falso o fraudulento para el pago de un siniestro o beneficio o que a sabiendas presente información falsa en una solicitud de seguro es culpable de un delito y puede estar sujeta al resarcimiento, multas o la reclusión en prisión, o cualquier combinación de estos.

Alaska: Una persona que, a sabiendas y con la intención de perjudicar, defraudar o engañar a una compañía de seguros, presente un reclamo que contiene información falsa, incompleta o engañosa puede ser procesada bajo la ley estatal.

Arizona: Para su protección, la ley de Arizona requiere que la siguiente declaración aparezca en este formulario: Cualquier persona que, a sabiendas, presente un reclamo falso o fraudulento para el pago de un siniestro está sujeta a sanciones penales y civiles.

Arkansas, Louisiana, Rhode Island, West Virginia: Cualquier persona que a sabiendas presente un reclamo falso o fraudulento para el pago de un siniestro o beneficio o que a sabiendas presente información falsa en una solicitud de seguro es culpable de un delito y puede estar sujeta a multas y a reclusión en prisión.

California: Para su protección, la ley de California requiere que lo siguiente aparezca en este formulario: Cualquier persona que, a sabiendas, presente un reclamo falso o fraudulento para el pago de un siniestro es culpable de un delito y puede estar sujeto a multas y reclusión en una prisión estatal.

Colorado: Es ilegal proporcionar a sabiendas hechos o información falsos, incompletos o engañosos a una compañía de seguros con el propósito de defraudar o intentar defraudar a la compañía. Las sanciones pueden incluir el encarcelamiento, multas, la denegación del seguro y daños civiles. Cualquier compañía de seguros o agente de una compañía de seguros que a sabiendas proporcione hechos o información falsos, incompletos o engañosos a un asegurado o reclamante con el propósito de defraudar o intentar defraudar al asegurado o reclamante con respecto a un acuerdo o laudo pagadero de los ingresos del seguro será denunciada a la división de seguros de Colorado dentro del departamento de agencias reguladoras.

Delaware: Cualquier persona que a sabiendas, y con la intención de perjudicar, defraudar o engañar a cualquier aseguradora, presenta una declaración de reclamo que contiene cualquier información falsa, incompleta o engañosa es culpable de un delito grave.

Distrito de Columbia: ADVERTENCIA: Es un delito proporcionar información falsa o engañosa a una aseguradora con el propósito de defraudar a la aseguradora o a cualquier otra persona. Las sanciones incluyen el encarcelamiento y/o multas. Además, una aseguradora puede denegar los beneficios del seguro si el solicitante proporcionó información falsa relacionada materialmente con un reclamo.

Florida: Cualquier persona que intencionalmente y con intención de perjudicar, defraudar o engañar a cualquier aseguradora presenta una declaración de reclamo o una solicitud que contenga información falsa, incompleta o engañosa es culpable de un delito grave de tercer grado.

Hawái: Para su protección, la ley de Hawái requiere que se le informe que presentar un reclamo fraudulento para el pago de una pérdida o un beneficio es un delito castigado con multas o reclusión, o ambos.

Idaho: Cualquier persona que a sabiendas, y con la intención de defraudar o engañar a cualquier compañía de seguros, presente una declaración que contiene cualquier información falsa, incompleta o engañosa es culpable de un delito grave.

Indiana: Cualquier persona que a sabiendas, y con la intención de defraudar a una aseguradora, presente una declaración de reclamo que contiene información falsa, incompleta o engañosa comete un delito grave.

Kentucky: Cualquier persona que, a sabiendas y con la intención de defraudar a una compañía de seguros o a otras personas, presente una declaración de reclamo en la que figure una información materialmente falsa, o que oculte información con el fin de tergiversar, así como información que oculte algún hecho material de esta, comete un acto de seguro fraudulento, que constituye un delito y está sujeto a procesamiento penal y/o a sanciones civiles.

Maine, Tennessee, Virginia, Washington: Es un delito proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguros con el fin de defraudar a la compañía. Las sanciones pueden incluir encarcelamiento, multas o una denegación de beneficios de seguro.

Maryland: Cualquier persona que a sabiendas presente un reclamo falso o fraudulento para el pago de un siniestro o beneficio o que a sabiendas o intencionalmente presente información falsa en una solicitud de seguro es culpable de un delito y puede estar sujeta multas y a reclusión en prisión.

Minnesota: Una persona que presenta un reclamo con la intención de defraudar o ayuda a cometer un fraude contra una aseguradora es culpable de un delito.

New Hampshire: Cualquier persona que, con el propósito de perjudicar, defraudar o engañar a cualquier compañía de seguros, presente una declaración de reclamo que contenga cualquier información falsa, incompleta o engañosa está sujeta a procesamiento y castigo por fraude de seguro según lo dispuesto en la sección 638.20 de los Estatutos Revisados Anotados (Revised Statutes Annotated, R.S.A).

Nueva Jersey: Cualquier persona que a sabiendas presente una declaración de reclamo que contenga cualquier información falsa o engañosa está sujeta a sanciones penales y civiles.

Nuevo México: Cualquier persona que a sabiendas presente un reclamo falso o fraudulento para el pago de un siniestro o beneficio o que a sabiendas presente información falsa en una solicitud de seguro es culpable de un delito y puede estar sujeta a multas civiles y sanciones penales.

Nueva York: Cualquier persona que, a sabiendas y con la intención de defraudar a una compañía de seguros o a otras personas, presente una declaración de reclamo en la que figure una información materialmente falsa, o que oculte información con el fin de tergiversar, o información que oculte algún hecho material, comete un acto de seguro fraudulento, que constituye un delito y además estará sujeta a una sanción civil que no exceda de $5,000 y el valor declarado del reclamo por cada violación.

Ohio: Cualquier persona que, con la intención de defraudar o sabiendo que está facilitando un fraude contra una aseguradora, presente una solicitud o presente un reclamo que contiene una declaración falsa o engañosa es culpable de fraude de seguro.

Oklahoma: ADVERTENCIA: Cualquier persona que a sabiendas, y con la intención de perjudicar, defraudar o engañar a cualquier aseguradora presente cualquier reclamo por los ingresos de una póliza de seguro que contiene cualquier información falsa, incompleta o engañosa es culpable de un delito grave.

Pensilvania: Cualquier persona que, a sabiendas y con la intención de defraudar a una compañía de seguros o a otras personas, presente una solicitud de seguro o declaración de reclamo en la que figure una información sustancialmente falsa, o que oculte información con el fin de engañar, o información que oculte algún hecho material, comete un acto de seguro fraudulento, que es un delito y somete a dicha persona a sanciones penales y civiles.

Texas: Cualquier persona que, a sabiendas, presente un reclamo falso o fraudulento para el pago de un siniestro es culpable de un delito y puede estar sujeto a multas y reclusión en una prisión estatal.

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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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学生意外事故与疾病保险索赔提交说明

适用于父母/法律监护人（或法定年龄的学生）

保险条款和条件

请在伤害或疾病发生前或发生后尽快熟悉保险条款和条件，包括：哪些活动在保险范围内；赔付；除外条款；要求和限制条款；重要的截止日期等。这些可以在校方的存档保单、用于确保保险范围的印刷小册子中找到，也可以在线获取或直接致电 (800) 827-4695 联系我们索取。

索赔表和报告

立即向学校官员报告学校相关的伤害情况，尽可能详细地提供。

向学校索取学生意外与疾病保险索赔表，并要求授权学校官员完整而清晰地填写表格的 A 部分。如果报告的伤害与学校无关，您可以自己填写 A 部分。每项伤害或病情只需要一份索赔表。

完整而清晰地填写 B 部分（缺少字段将导致延迟）按要求提供签名，写上日期，然后寄回我们的办公室，并随附您的明细账单和任何其他适用的保险或健康计划的赔付说明 (EOB)。

请注意：下一页上的索赔表必须用英文填写。请致电我们的办公室寻求帮助。

寻找医疗服务提供商

您可以自由地将您的孩子带到任何获得正式许可的医疗服务提供商，但如果您向根据 *First Health Network* 或 *First Choice Health Network*（仅限 WA）签约的医疗服务提供商寻求医疗服务，则自付费用可能会减少。可以通过以下方式找到签约的提供商 www.firsthealth.com (800) 226-5116 或 www.fchn.com (800) 231-6935。如果您的孩子也由 HMO 进行了承保，谨记如果您寻求未经 HMO 预先授权的网络外服务，许多学校支付的一揽子计划的赔付可能会减少。此潜在赔付限制不适用于我们任何单独购买的计划，也不适用于紧急护理。

在寻求治疗时

向提供商的结算/入院人员提供您的主要保险/健康计划信息（如果适用）。

如果您为孩子购买了我们的个人计划，请出示学生保险证。如果您的孩子在学校支付的一揽子计划承保范围内，请告知结算人员，并识别学校/学区。无论两者中的哪一种情况，请说明您的孩子的承保范围是“二级事故医疗费用保险”还是意外事故与疾病保险，而不是有时被称为“第三方”的保险。您的孩子是被保险人。
要求结算人员将 Myers-Stevens & Toohey 作为付款人添加到他们的系统中，并直接向我们发送上述明细账单（首选！）或向您发送相同账单然后转发给我们。让提供者知道您正在为他们争取赔付，可能有助于流程顺利进行。如果您有困难，请与我们联系，我们很乐意为您提供帮助。

如果您的孩子有其他保险或健康保险

向主要计划提交（Medicaid 除外）索赔，并在处理完毕后向我们发送其“赔付说明”或“EOB”的副本。

我们需要从为您孩子治疗的提供商那里获取什么资料*

为了评估您的索赔并提供赔付，我们需要从提供治疗的任何提供商处获得完整的明细账单。这些被称为 HCFA 1500 或 CMS 1500 表单来自医生等提供者，以及被称为 UB04 表单来自医院和外科中心等设施。它们包含以下必需信息：

- 服务日期
- 费用结算
- 诊断代码 - 这些代码告诉我们您的孩子有什么问题
- 程序或收入代码 - 这些代码告诉我们通过何种方法来评估/处理问题
- 提供商税 ID 号 - 在向提供商分配赔付时发行 W-9 需要该编号
- 国家提供者标识符 (NPI) - 需要遵守联邦法规

注 - 我们不能使用由提供商，主要健康计划 EOB 或支付收据中的“声明”来代替上述所需的明细账单。

**如果您有 Kaiser，请向 Kaiser 会员服务部门索要包含上述信息的“礼貌性声明”。请确保提交的文件中表明您有义务自掏腰包支付哪部分的费用（如果有的话）。*

最终步骤

将：1) 完整填写索赔表；2) 明细账单；3) 其他保险/健康计划 EOB（如适用）发送至：

MYERS-STEVENS & TOOHEY
联系人：索赔部门
26101 Marguerite Parkway
Mission Viejo，CA。92692

或 **传真：(949) 348-9350** *或* **电子邮件：claims@myers-stevens.com**

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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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26101 Marguerite Parkway, Mission Viejo, CA 92692-3203
Office (800) 827-4695 • Fax (949) 348-9350 • claims@myers-stevens.com
CA License #0425842

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

CHUBB®

First Health®

First Choice Health
PPO Network - ***WA***

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Bảo hiểm Tai nạn và Bệnh tật cho Học sinh HƯỚNG DẪN NỘP YÊU CẦU THANH TOÁN BẢO HIỂM DÀNH CHO PHỤ HUYNH/NGƯỜI GIÁM HỘ HỢP PHÁP (hoặc học sinh ở độ tuổi hợp pháp)

Điều khoản và điều kiện bao trả

Trước hoặc ngay sau khi xảy ra chấn thương hoặc bệnh tật, quý vị vui lòng đọc kỹ các điều khoản và điều kiện bao trả, bao gồm: hoạt động được bao trả; quyền lợi; trường hợp ngoại lệ; yêu cầu và giới hạn; hạn chót quan trọng, v.v. Quý vị có thể tìm những thông tin này trong các chính sách được lưu hồ sơ tại văn phòng ban quản lý nhà trường, các tài liệu in cho mục đích thu xếp bao trả, qua trực tuyến hoặc liên hệ trực tiếp với chúng tôi theo số (800) 827-4695.

Biểu mẫu yêu cầu thanh toán bảo hiểm và báo cáo

Báo cáo các chấn thương liên quan đến trường học ngay cho các cán bộ nhà trường, mô tả càng chi tiết càng tốt.

Yêu cầu nhà trường cung cấp biểu mẫu yêu cầu thanh toán Bảo hiểm Tai nạn và Bệnh tật cho Học sinh, đồng thời nhờ một cán bộ nhà trường được ủy quyền điền ĐẦY ĐỦ VÀ RÕ RÀNG vào Phần A trong biểu mẫu này. Nếu chấn thương được báo cáo không liên quan đến trường học, quý vị có thể tự điền vào Phần A. Quý vị chỉ cần nộp một mẫu yêu cầu thanh toán bảo hiểm đối với mỗi chấn thương hoặc bệnh trạng.

Điền ĐẦY ĐỦ VÀ RÕ RÀNG vào Phần B (thời gian xử lý sẽ chậm hơn nếu quý vị điền thiếu), ký vào những chỗ yêu cầu, ghi ngày và gửi lại mẫu đơn cho văn phòng của chúng tôi cùng với hóa đơn ghi chi tiết các hạng mục và Bảng Giải thích Quyền lợi Bảo hiểm (EOB) từ bất cứ chương trình bảo hiểm hoặc chương trình sức khỏe nào khác có áp dụng.

XIN LƯU Ý: Quý vị cần điền vào Biểu mẫu Yêu cầu Thanh toán Bảo hiểm trên trang tiếp theo bằng tiếng Anh. Vui lòng gọi đến văn phòng của chúng tôi để được hỗ trợ.

Tìm nhà cung cấp dịch vụ chăm sóc sức khỏe

Quý vị hoàn toàn có thể đưa con mình đến thăm khám tại bất kỳ nhà cung cấp dịch vụ sức khỏe nào được cấp phép phù hợp. Tuy nhiên, chi phí phát sinh có thể giảm xuống nếu quý vị tìm kiếm chăm sóc từ những nhà cung cấp có hợp đồng với *First Health Network* hoặc *First Choice Health Network* (chỉ tại WA). Quý vị có thể tìm các nhà cung cấp có ký kết hợp đồng tại www.firsthealth.com (800) 226-5116 hoặc www.fchn.com (800) 231-6935. Nếu con của quý vị cũng được bao trả theo một chương trình HMO, xin lưu ý rằng các quyền lợi trong nhiều chương trình bảo hiểm tổng quát do nhà trường chi trả của chúng tôi có thể sẽ giảm đi nếu quý vị sử dụng các dịch vụ ngoài mạng lưới mà không được HMO của quý vị cho phép trước. Giới hạn có thể có về quyền lợi này không áp dụng cho bất kỳ chương trình bảo hiểm cá nhân nào của chúng tôi và không áp dụng cho trường hợp cấp cứu.

Trường hợp tìm dịch vụ điều trị

Cung cấp thông tin về chương trình bảo hiểm/sức khỏe chính của quý vị (nếu có) cho nhân viên lập hóa đơn/tiếp nhận của nhà cung cấp.

Nếu quý vị đã mua một trong các chương trình bảo hiểm cá nhân của chúng tôi cho con mình, hãy xuất trình Thẻ bảo hiểm học sinh của con quý vị. Nếu con quý vị được hưởng chương trình bảo hiểm tổng quát do nhà trường chi trả, hãy nói cho nhân viên lập hóa đơn biết và xác định nhà trường/học khu đó. Dù trong trường hợp nào, quý vị cũng cần giải thích rằng con mình thuộc diện "bảo hiểm chi phí y tế do tai nạn phụ" hoặc bảo hiểm tai nạn và bệnh tật, và rằng đây KHÔNG phải là hình thức bảo hiểm "cho bên thứ ba" như đôi khi được đề cập đến. Con của quý vị là người được bảo hiểm.

Yêu cầu người lập hóa đơn thêm Myers-Stevens & Toohey vào hệ thống của họ với tư cách bên chi trả, đồng thời gửi thẳng cho chúng tôi hóa đơn chi tiết được mô tả ở trên (nên dùng cách này!) hoặc gửi hóa đơn đó cho quý vị để quý vị chuyển tiếp cho chúng tôi. Quá trình này sẽ dễ dàng hơn nếu quý vị cho nhà cung cấp biết là mình đang chuyển quyền thụ hưởng cho họ. Nếu quý vị gặp khó khăn, vui lòng liên hệ với chúng tôi để được hỗ trợ bất cứ lúc nào.

Nếu con của quý vị có bảo hiểm hoặc bao trả sức khỏe khác

Hãy nộp yêu cầu thanh toán bảo hiểm với chương trình bảo hiểm chính đó (trừ Medicaid) và gửi cho chúng tôi bản sao "Bảng Giải thích Quyền lợi Bảo hiểm" hay còn gọi là "EOB" của họ sau khi yêu cầu được xử lý.

Thông tin chúng tôi cần từ phía nhà cung cấp thăm khám cho con quý vị*

Để đánh giá yêu cầu thanh toán bảo hiểm và cung cấp quyền lợi bảo hiểm, chúng tôi cần có hóa đơn chi tiết từ các nhà cung cấp đã thực hiện thăm khám. Các hóa đơn này được gọi là mẫu HCFA 1500 hoặc CMS 1500 nếu đó là nhà cung cấp (như bác sĩ) và mẫu UB04 nếu đó là cơ sở y tế (như bệnh viện và trung tâm phẫu thuật). Những hóa đơn này chứa các thông tin bắt buộc sau:

- Ngày thực hiện Dịch vụ
- Chi phí được Lập hóa đơn
- Mã Chẩn đoán - những mã này cho chúng tôi biết con quý vị gặp vấn đề gì
- Mã Quy trình hoặc Mã Doanh thu - những mã này cho chúng tôi biết hoạt động đánh giá/điều trị vấn đề
- Mã số Thuế của Nhà cung cấp - dùng để cấp mẫu W-9 khi chuyển quyền thụ hưởng cho nhà cung cấp
- Mã định danh Nhà cung cấp Toàn quốc (NPI) - cần cho việc tuân thủ các quy định của Liên bang

LƯU Ý – chúng tôi không thể sử dụng "bản kê khai" của nhà cung cấp, EOB của chương trình sức khỏe chính hoặc biên lai thanh toán thay cho hóa đơn chi tiết mà bắt buộc phải cung cấp theo mô tả ở trên.

**Nếu quý vị sử dụng dịch vụ của Kaiser, hãy yêu cầu bộ phận Dịch vụ Hội viên Kaiser cung cấp "bản kê khai tự nguyện", trong đó có các thông tin nêu trên. Vui lòng đảm bảo rằng tài liệu mà quý vị gửi phải nêu rõ phần chi phí mà quý vị phải tự thanh toán (nếu có).*

Các Bước Cuối cùng

Gửi: 1) Mẫu yêu cầu thanh toán bảo hiểm đã hoàn tất; 2) Hóa đơn chi tiết; 3) EOB của chương trình bảo hiểm/sức khỏe khác (nếu áp dụng) đến:

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

HOẶC **Fax: (949) 348-9350** *HOẶC* **Email: claims@myers-stevens.com**

myers | stevens | toohey

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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