



Coverage terms and conditions

If your child is injured, 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 your school or school district or by contacting Myers-Stevens & Toohey at (800) 827-4695.



Claim form and reporting

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

Request a claim form from the school and ask an authorized school official to **completely and clearly** fill out Part A of the form. 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 Myers-Stevens & Toohey along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.



When treatment is sought

- Give the provider's billing/admissions department your primary insurance/health plan information (if applicable).
- Let the provider know that your child has student accident coverage through his/her school and that medical expense benefits are provided on an excess or secondary basis.
- 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 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 your child is being treated for
- 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.



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: claims@myers-stevens.com

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

STUDENT ACCIDENT COVERAGE CLAIM FORM

"School-Time" plan (\$25,000 maximum benefits per injury) is fully self-funded by APRA and the catastrophic injury and other insured coverages are underwritten by ACE American Insurance Company (a CHUBB member company)

PART A SCHOOL STATEMENT

NAME OF CLAIMANT		FIRST	MI	LAST	AGE	GRADE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH
								MO DAY YR
ADDRESS OF CLAIMANT		CITY			STATE	ZIP CODE		
IS THE CLAIMANT A:								
<input type="checkbox"/> STUDENT <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER _____								
NAME OF SCHOOL					NAME OF DISTRICT			
SCHOOL MAILING ADDRESS		CITY			STATE	ZIP CODE		SCHOOL TELEPHONE NUMBER
DURING WHAT ACTIVITY DID THE INJURY OCCUR?								
<input type="checkbox"/> INTERSCHOLASTIC PRACTICE <input type="checkbox"/> INTERSCHOLASTIC GAME <input type="checkbox"/> P.E. <input type="checkbox"/> CLASSROOM <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> TRAVEL <input type="checkbox"/> AT HOME <input type="checkbox"/> FIELD TRIP OTHER _____								
WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL-SPONSORED AND SUPERVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF SPORT:		DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, LIST NAME OF SPORTS ORGANIZATION:						If YES, name of plan:		
DATE OF INJURY/SICKNESS	TIME OF INJURY	WHAT PART AND/OR AREA OF THE BODY WAS INJURED?			<input type="checkbox"/> RIGHT _____	HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN?		
	: A.M. / P.M. (Circle One)	(Additional details may be provided below)			<input type="checkbox"/> LEFT _____			
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?		DATE SCHOOL WAS NOTIFIED	
					<input type="checkbox"/> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME AND TITLE OF OFFICIAL COMPLETING FORM			EMAIL		SIGNATURE		DATE SIGNED	
					X			

PART B STUDENT INFORMATION - TO BE COMPLETED BY PARENT OR GUARDIAN

NAME OF CLAIMANT'S (STUDENT'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, NAME OF PLAN(S)		<input type="checkbox"/> YES <input type="checkbox"/> NO	POLICY NUMBER(S)		IS THE CLAIMANT A MEDICARE BENEFICIARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF CLAIMANT'S EMPLOYER (if applicable)		ADDRESS			PHONE NUMBER	
NAME OF FATHER OR LEGAL GUARDIAN		EMAIL		MOBILE TELEPHONE NO.		HOME TELEPHONE NO.
ADDRESS		CITY		STATE	ZIP CODE	
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed				WORK TELEPHONE		
ADDRESS OF EMPLOYER		CITY		STATE	ZIP CODE	
NAME OF MOTHER OR LEGAL GUARDIAN		EMAIL		MOBILE TELEPHONE NO.		HOME TELEPHONE NO.
ADDRESS		CITY		STATE	ZIP CODE	
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> 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 & Toohy Co., Inc. (MST) or APRA 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/HCFR 1500s and UB04s. If the claim is reportedly the result of participating in a School activity, I authorize MST to share information concerning this claim as necessary with representatives of the School/School District. 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 injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law. I have read and acknowledge the General Fraud Warning above.

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