myers | stevens | toohey

Student Accident & Sickness Insurance
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS and COVERED VOLUNTEERS (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 officials, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized 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 primary insurance or health plan.



Finding a health provider

You are free to seek treatment from 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.

NOTE - If primary coverage exists through a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO), please know that benefits payable under many of our blanket plans may be reduced if you seek out-of-network services that are not preauthorized by the HMO or EPO. This potential benefit limitation does not apply to any of our voluntary-purchase 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, present your student insurance ID Card. If coverage is provided 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 you have 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 covered claimant 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 below 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 you have other insurance or health coverage

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



What we need from providers*

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

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 _____

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

SCHOOL/PARISH MAILING ADDRESS CITY STATE ZIP CODE | SCHOOL/PARISH CONTACT PHONE # WITH EXTENSION

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. | WHAT **PART** AND/OR **AREA** OF THE BODY WAS INJURED? (Additional details should 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 THE ACCIDENT WAS REPORTED TO OFFICIALS

NAME OF OFFICIAL COMPLETING FORM | OFFICIAL'S TITLE | SIGNATURE X | DATE SIGNED | OFFICIAL'S EMAIL ADDRESS

PART B PARENT / LEGAL GUARDIAN / CLAIMANT 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)

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

SECTIONS BELOW SHOULD BE COMPLETED AND SIGNED BY THE CLAIMANT IF 18 OR OLDER

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 following the expiration of the applicable policy benefit period, 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.

myers | stevens | toohey

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***