SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school-related injuries to the school within 72 hours
2. Complete this form
3. Attach all bills
4. Mail to →

Myers-Stevens & Toohey & Co., Inc.
26101 marguerite parkway
mission viejo, california 92692-3203
office (800) 827-4695 • fax (949) 348-2630

STUDENT INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (PARENT OR LEGAL GUARDIAN MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)

NAME OF INSURED PERSON (FIRST / MI / LAST)				STUDENT I.D. # FROM I.D. CARD

NAME OF SCHOOL	NAME OF SCHOOL DISTRICT	AGE	GRADE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO / DAY / YR
					/ /

ADDRESS OF SCHOOL	CITY	STATE	ZIP CODE

DATE OF INJURY/SICKNESS MO / DAY / YR	TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)	INJURY OCCURRED: PLEASE ✔ ONE ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel ☐ At Home ☐ Field Trip ☐ Other_____	TYPE OF SPORT
/ /	:		

DETAILS OF SICKNESS OR HOW THE INJURY OCCURRED. **PLEASE BE SPECIFIC**	WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) ☐ YES ☐ NO

WHAT **PART** OF THE BODY WAS INJURED?	HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

NAME AND TITLE OF SCHOOL SUPERVISOR	WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO	DATE SCHOOL WAS NOTIFIED OF ACCIDENT

NAME OF SCHOOL OFFICIAL	SIGNATURE OF SCHOOL OFFICIAL	DATE SIGNED	SCHOOL TELEPHONE NO.
	X		( )

PART B PARENT OR LEGAL GUARDIAN STATEMENT *(PLEASE PRINT OR TYPE CLEARLY)*

IS THIS STUDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS?

☐ NO ☐ YES IF YES, NAME OF ORGINIZATION (S)

NAME OF FATHER OR LEGAL MALE GUARDIAN	DATE OF BIRTH OF FATHER OR LEGAL MALE GUARDIAN	HOME TELEPHONE NO.
		( )

ADDRESS	CITY	STATE	ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE AND EXTENSION NO.
	( )

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR LEGAL MALE GUARDIAN	POLICY NUMBER	TELEPHONE NO.
		( )

MAILING ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP CODE

NAME, ADDRESS AND PHONE NO. OF STUDENT'S FAMILY PHYSICIAN	CITY	STATE	ZIP CODE	TELEPHONE NO.
				( )

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN	DATE OF BIRTH OF MOTHER OR LEGAL FEMALE GUARDIAN	HOME TELEPHONE NO.
		( )

ADDRESS	CITY	STATE	ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE AND EXTENSION NO.
	( )

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY OF MOTHER OR LEGAL FEMALE GUARDIAN	POLICY NUMBER	TELEPHONE NO.
		( )

MAILING ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP CODE

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.
I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

PARENT OR LEGAL GUARDIAN SIGNATURE

X

RELATIONSHIP TO STUDENT DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____

CLAIM FILING PROCEDURE

1. Report school-related injuries to the school within 72 hours.
2. Have school complete PART A. (Parents or legal guardian may fill out PART A if injury is not school related.)
3. Claimant, parent or guardian complete PART B.
4. **IMPORTANT: Both parts must be completed <u>in full</u> or claim will not be processed.**
5. Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**
6. At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).
7. When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office in a timely fashion to expedite the processing of your claim.
8. If you have any questions, please call our office at 800-827-4695.

NON-DUPLICATION OF BENEFITS: In order to keep premiums as affordable as possible, these plans pay benefits on a non-duplicating basis. This means, if a person is covered by one or more of our plans and by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount.

COMMONLY ASKED QUESTIONS

Q: Do I have to go to a specific doctor or hospital?

A: *No, you can go to the doctor or hospital of your choice. However, if you go to a provider within the provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating provider in your area, call 800-226-5116 or log on to <u>www.myfirsthealth.com</u>. In Washington or Idaho, call 800-823-6935 or log on to: <u>www.fchn.com</u>.*

Q: Do I need to attach a claim form for each bill?

A: *No, only one claim form is required per injury or sickness.*

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26101 marguerite parkway
mission viejo, california 92692-3203
offfic (949) 348-0656
fax (949) 348-2630

First Health®

Underwritten by:

BCS

Underwritten by:
ACE American Insurance Company

First Choice Health
PPO Network
WA, ID

For residents of 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.

For residents of Oregon: WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

For residents of 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.