Student Accident Coverage
CLAIM FILING INSTRUCTIONS

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

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 blanket plan 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 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: claims@myers-stevens.com**

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

STUDENT ACCIDENT COVERAGE CLAIM FORM

myers | stevens | toohey

PART A SCHOOL STATEMENT

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 | NAME OF DISTRICT

SCHOOL MAILING ADDRESS | CITY | STATE | ZIP CODE

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP
OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION:

TYPE OF SPORT:

DOES THE SCHOOL 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 WAS NOTIFIED

NAME AND TITLE OF OFFICIAL COMPLETING FORM

SIGNATURE
X

DATE SIGNED

SCHOOL 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
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 | 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 | 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 the AML/JIA 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 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 _____