Claim Kit

STUDENT ACCIDENT COVERAGE

How to File a Claim

CLAIM FORM

- **Complete and submit the Claim Form to ISDA Claims Administrator no later than 90 days after the date of injury.** You should not wait until you have all the bills and Explanation of Benefits because you may miss a due date.

- **DO NOT** leave the Claim Form with the physician or hospital.

- A school official must complete Part A of the Claim Form. The parent or guardian must complete Part B – Statement from Parent or Guardian. Do not leave any blank spaces or write "N/A" in any space.

ITEMIZED BILLS

- **Itemized bills must be submitted to ISDA Claims Administrator immediately as you receive them, but no later than 90 days after the date of treatment.** Itemized bills include (1) CMS-1500 (physician/ancillary charges) and (2) UB04 (hospital charges). All bills must include patient's name, date of service, total charge, procedure and diagnosis codes.
- If you already paid the bill(s), include the receipt or a copy of your cancelled check. Payment will be made to the provider(s) of service (hospital, physician, radiologist, etc.) unless a paid receipt or statement from the provider accompanies the itemized bill showing the bill was paid.

EXPLANATION OF BENEFITS (EOB)

- Your medical/dental provider must submit the bills to your primary insurance carrier first. You will receive an Explanation of Benefits (EOB) from your primary insurance carrier or claims administrator (Blue Cross, Group Health, Prudential Insurance, etc.) after they have processed your claim. **EOBs should be submitted to ISDA Claims Administrator immediately as you receive them, but no later than 180 days after the date of treatment.** Your claim will be held pending receipt of this information.

GENERAL INFORMATION

- Send claim documents to the following address within the required time frames stated above.

Student Accident Claims
ISDA Claims Administrator
155 N. Wacker, Suite 3700
Chicago, IL 60606
Telephone: (800) 419-3206 or (312) 930-6143 Facsimile: (312) 930-7232

- Benefits will not be paid unless you submit itemized bills and Explanation of Benefits, if you have other insurance, and they are submitted within the required time frames.

- Benefits under the Student Accident Coverage Plan are not guaranteed. Upon our receipt of acceptable, complete and timely claim documentation, benefits will be determined in accordance with the terms and conditions of the Plan of Coverage.

- Review the 2017-2018 Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. Please contact your child's school for a copy of the brochure, if you have not received one or download it from www.wcsit-isda.com/sa. You should remove the Student Accident Excess Coverage card from the brochure and show it to the providers of service.

- Please remember that this plan is **EXCESS** to all other valid coverage. You **MUST** file a claim with your primary insurance carrier first, even if you have a large deductible.

- Students must be treated by a licensed medical or dental provider **within 30 days** from the date of the covered injury.

ISDA Illinois School District Agency

ISDA Student Accident Claims Administrator

2017-2018 STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to ISDA Claims Administrator by the due dates.

1) **Claim Form must be submitted no later than 90 days after the date of injury.**
2) **Itemized bills must be submitted no later than 90 days after the date of treatment.**
3) **Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**

#1, #2 & #3 listed above must all be submitted if you have other insurance

INSTRUCTIONS: **PLEASE RETAIN A COPY FOR YOUR FILES**

1. The school official must complete Part A.
2. The Insured's parent/guardian must complete Part B.
3. In case of dental charges, the attending dentist **must** complete the Attending Dentist's Statement on the reverse side of this form.

PART A: NOTICE OF INJURY FROM SCHOOL (Please type or print)

1. Name of School _____ School District Name _____

   School Address _____ _____ _____ _____
   (City) (State) (Zip)

2. School Contact Name _____ School Contact Phone Number _____

3. Name of Student _____

4. Date of Injury _____ Time ___:___AM ___:___PM Under whose supervision? _____ Was he/she a witness? _____

5. The injury was incurred while the student was participating in: (*please check*)

INTERSCHOLASTIC SPORTS
( ) Practice
( ) Game
Name of Sport _____

NON-INTERSCHOLASTIC SPORTS – Where did accident occur?
( ) Travel to/from school ( ) Non-school activity
( ) In classroom ( ) Other – Activity?
( ) Physical Education _____
( ) On school grounds ( ) Recess

6. Part of the body injured ( ) Right ( ) Left _____

7. Describe exactly how injury happened (Please be specific) _____

_____

Reported by _____ _____ _____
Signature of School Official Title Date

PART B: STATEMENT FROM PARENT OR GUARDIAN *(Important Information on Reverse Side)* (Please type or print)

1. Name of Parent _____ Relationship to Student _____

   Home Address _____ (_____)_____
   Home Phone Number

   _____ _____ _____ (_____)_____
   City State Zip Cell Phone Number

2. Father's Occupation _____ Employer _____ _____
   Phone Number

3. Mother's Occupation _____ Employer _____ _____
   Phone Number

4. Student's Date of Birth _____ Grade _____ M / F Student's Social Security Number _____

5. **THIS AREA MUST BE COMPLETED.** Is student covered under any other insurance plan? Yes ____ No ____ List all other insurance coverage in force

   Name of Insurance Company _____ Group ____ Individual ____ Policy #_____

   Phone Number (_____)_____ Whose insurance is it? ( ) Mother ( ) Father ( ) Guardian

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to ISDA Claims Administrator. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim.

_____ _____ _____
Date Print Name of Student Signature of Parent or Guardian

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested on this form may upon conviction be subject to fine or imprisonment.*

Form ISDACF (7/17)

ISDA Illinois School District Agency

ISDA Student Accident Claims Administrator

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

- **Complete and submit the Claim Form to ISDA Claims Administrator no later than 90 days after the date of injury.**
- **DO NOT** leave this Claim Form with the physician or hospital.
- Review the 2017-2018 Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. Please contact your child's school for a copy of the brochure, if you have not received one or download it from www.wcsit-isda.com/sa. An identification card is included in the brochure. Please cut out the ID card and carry it with you. It should be presented to the hospital, Doctor and Dentist along with your primary insurance ID card (if applicable) whenever you seek medical/dental attention for a school related injury.
- A school official must complete Part A for all school-related injuries. The parent or guardian must complete **all** questions in Part B – Statement from Parent or Guardian.
- Students must be treated by a licensed medical or dental provider **within 30 days** after the date of the covered injury.
- **Itemized bills** must be submitted to ISDA Claims Administrator **no later than 90 days** after the date of treatment. All bills must include the diagnosis and procedure codes.
- Please remember that this plan is **EXCESS** to all other valid coverages. If you have other insurance, you **MUST** file a claim with your primary insurance carrier first, even if you have a large deductible. You should not wait until you have all the bills and EOBs because you may miss a due date.
- When you receive the **Explanation of Benefits (EOB)** from your primary insurance carrier or claims administrator, send them to ISDA Claims Administrator **no later than 180 days** after the date of treatment.
- All documents should be sent to the following address within the **required time frames**: Student Accident Claims, ISDA Claims Administrator, 155 N. Wacker, Suite 3700, Chicago, IL 60606 or faxed to (312) 930-7232.
- For additional questions, please call (800) 419-3206 or (312) 930-6143.

ATTENDING DENTIST'S STATEMENT

1. Date of Injury_____ 2. If Prosthesis, is this initial placement?_____
3. Were the teeth sound or natural prior to the current treatment? _____YES _____NO
4. Are any services covered by another plan? If so name plan? _____YES _____NO

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

Print Dentist's Name _____ Dentist Signature _____

Street Address _____ Date _____

City _____ State _____ Zip _____ Telephone _____

_____ Federal tax ID Number (must be included)