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学生意外事故与疾病保险
索赔提交说明

适用于父母/法律监护人（或法定年龄的学生）

保险条款和条件

请在伤害或疾病发生前或发生后尽快熟悉保险条款和条件，包括：哪些活动在保险范围内；赔付；除外条款；要求和限制条款；重要的截止日期等。这些可以在校方的存档保单、用于确保保险范围的印刷小册子中找到，也可以在线获取或直接致电 (800) 827-4695 联系我们索取。

索赔表和报告

立即向学校官员报告学校相关的伤害情况，尽可能详细地提供。

向学校索取学生意外与疾病保险索赔表，并要求授权学校官员完整而清晰地填写表格的 A 部分。如果报告的伤害与学校无关，您可以自己填写 A 部分。每项伤害或病情只需要一份索赔表。

完整而清晰地填写 B 部分（缺少字段将导致延迟）按要求提供签名，写上日期，然后寄回我们的办公室，并随附您的明细账单和任何其他适用的保险或健康计划的赔付说明 (EOB)。

请注意：下一页上的索赔表必须用英文填写。请致电我们的办公室寻求帮助。

寻找医疗服务提供商

您可以自由地将您的孩子带到任何获得正式许可的医疗服务提供商，但如果您向根据 *First Health Network* 或 *First Choice Health Network*（仅限 WA）签约的医疗服务提供商寻求医疗服务，则自付费用可能会减少。可以通过以下方式找到签约的提供商 www.firsthealth.com (800) 226-5116 或 www.fchn.com (800) 231-6935。如果您的孩子也由 HMO 进行了承保，谨记如果您寻求未经 HMO 预先授权的网络外服务，许多学校支付的一揽子计划的赔付可能会减少。此潜在赔付限制不适用于我们任何单独购买的计划，也不适用于紧急护理。

在寻求治疗时

向提供商的结算/入院人员提供您的主要保险/健康计划信息（如果适用）。

如果您为孩子购买了我们的个人计划，请出示学生保险证。如果您的孩子在学校支付的一揽子计划承保范围内，请告知结算人员，并识别学校/学区。无论两者中的哪一种情况，请说明您的孩子的承保范围是“二级事故医疗费用保险”还是意外事故与疾病保险，而不是有时被称为“第三方”的保险。您的孩子是被保险人。
要求结算人员将 Myers-Stevens & Toohey 作为付款人添加到他们的系统中，并直接向我们发送上述明细账单（首选！）或向您发送相同账单然后转发给我们。让提供者知道您正在为他们争取赔付，可能有助于流程顺利进行。如果您有困难，请与我们联系，我们很乐意为您提供帮助。

如果您的孩子有其他保险或健康保险

向主要计划提交（Medicaid 除外）索赔，并在处理完毕后向我们发送其“赔付说明”或“EOB”的副本。

我们需要从为您孩子治疗的提供商那里获取什么资料*

为了评估您的索赔并提供赔付，我们需要从提供治疗的任何提供商处获得完整的明细账单。这些被称为 HCFA 1500 或 CMS 1500 表单来自医生等提供者，以及被称为 UB04 表单来自医院和外科中心等设施。它们包含以下必需信息：

- 服务日期
- 费用结算
- 诊断代码 - 这些代码告诉我们您的孩子有什么问题
- 程序或收入代码 - 这些代码告诉我们通过何种方法来评估/处理问题
- 提供商税 ID 号 - 在向提供商分配赔付时发行 W-9 需要该编号
- 国家提供者标识符 (NPI) - 需要遵守联邦法规

注 - 我们不能使用由提供商，主要健康计划 EOB 或支付收据中的“声明”来代替上述所需的明细账单。

**如果您有 Kaiser，请向 Kaiser 会员服务部门索要包含上述信息的“礼貌性声明”。请确保提交的文件中表明您有义务自掏腰包支付哪部分的费用（如果有的话）。*

最终步骤

将：1) 完整填写索赔表；2) 明细账单；3) 其他保险/健康计划 EOB（如适用）发送至：

MYERS-STEVENS & TOOHEY
联系人：索赔部门
26101 Marguerite Parkway
Mission Viejo，CA。92692

或 **传真：(949) 348-9350** *或* **电子邮件：claimsinfo@myers-stevens.com**

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STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (Parent or legal guardian may complete Part A if injury is not school 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 _____

ID # FROM ID CARD (If applicable)

NAME OF SCHOOL

NAME OF DISTRICT (if applicable)

SCHOOL MAILING ADDRESS | CITY | STATE | ZIP CODE

INJURY OCCURED: ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ 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:

DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? YES ☐ NO ☐
If YES, name of plan:

DATE OF INJURY/SICKNESS MO / DAY / YR

TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)

WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT

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
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 | 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 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 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 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.

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