Seguro de enfermedades y accidentes para estudiantes
INSTRUCCIONES PARA PRESENTAR RECLAMOS

PARA PADRES/TUTORES LEGALES (o estudiantes de edad legal)

Términos y condiciones de cobertura

Antes de que ocurra una lesión o enfermedad o tan pronto como sea posible posteriormente, familiarícese con los términos y condiciones de la cobertura, los cuales incluyen: qué actividades están cubiertas; beneficios; exclusiones; requisitos y limitaciones; fechas límite importantes, etc. Puede encontrarlos en las pólizas que se encuentran en los archivos de las autoridades escolares, en folletos impresos que se usan para asegurar la cobertura, en línea o poniéndose en contacto con nosotros directamente al (800) 827-4695.

Formulario de reclamos e informe

Informe inmediatamente al personal escolar sobre lesiones relacionadas con la escuela proporcionando la mayor cantidad de detalles que sea posible.

Solicite a la escuela un formulario de reclamo de Seguro de enfermedades y accidentes para estudiantes y pídale a una autoridad competente de la escuela que llene la Parte A del formulario DE MANERA COMPLETA Y LEGIBLE. Si le lesión que va a informar no está relacionada con la escuela, puede llenar usted mismo la Parte A. Solo se requiere un formulario de reclamo por lesión o enfermedad.

Llene DE MANERA COMPLETA Y LEGIBLE la Parte B (los campos faltantes causarán demoras), proporcione las firmas donde se soliciten, escriba la fecha y entréguelo a nuestra oficina junto con sus facturas detalladas y las Explicaciones de beneficios (Explanations of Benefits, EOB) de cualquier otro plan de seguro o plan de salud aplicable.

TÉNGALO EN CUENTA: El formulario de reclamo que se encuentra en la próxima página debe completarse en inglés. Llame a nuestra oficina si necesita ayuda.

Encontrar un proveedor de atención médica

Usted tiene la libertad de llevar a su hijo a cualquier proveedor de salud autorizado adecuadamente pero los gastos directos pueden reducirse si se hace atender con proveedores contratados de *First Health Network* o *First Choice Health Network* (solo WA). Puede encontrar proveedores contratados en www.firsthealth.com (800) 226-5116 o en www.fchn.com (800) 231-6935. Si su hijo también tiene cobertura a través de una Organización para el Mantenimiento de la Salud (Health Maintenance Organization, HMO) sepa que los beneficios de muchos de nuestros planes generales pagados por la escuela pueden reducirse si usted busca servicios fuera de la red que no estén autorizados previamente por su HMO. Esta limitación potencial de beneficios no se aplica a ninguno de nuestros planes adquiridos individualmente y no se aplica a la atención de emergencia.

Cuando pida atención

Proporcione a la persona encargada de la facturación/admisión del proveedor la información de su seguro médico principal (si corresponde).

Si usted adquirió uno de nuestros planes individuales para su hijo, presente su tarjeta de identificación de seguro estudiantil. Si su hijo está cubierto por un plan general pagado por la escuela, hágaselo saber a la persona encargada de la facturación e identifique la escuela o el distrito escolar. En cualquier caso, explique que la cobertura de su hijo es un "seguro secundario de gastos médicos por accidente" o un seguro de accidente y enfermedad y que NO es lo que a veces se denomina un seguro de "terceros". Su hijo es el asegurado.

Pídale a la persona encargada de facturación que añada a Myers-Stevens & Toohey a su sistema como pagador y que directamente nos envíe (¡preferiblemente!) las facturas detalladas que se describieron anteriormente o que le envíe las mismas facturas para que nos las reenvíe a nosotros. Informarle al proveedor que le está asignando beneficios puede ayudar a facilitar el proceso. Si tiene problemas, comuníquese con nosotros y con gusto lo ayudaremos.

Si su hijo tiene otro seguro o cobertura de salud

Presente un reclamo ante ese plan primario (excepto Medicaid) y envíenos copias de su "Explicación de beneficios" o "EOB (Explanation of Benefits)" una vez procesado.

Qué necesitamos de parte de los proveedores que atienden a su hijo*

Con el fin de evaluar su reclamo y proporcionarle beneficios, necesitaremos facturas completamente detalladas de cualquier proveedor que lo haya atendido. Estos formularios son el HCFA 1500 o el CMS 1500 si son de proveedores tales como médicos y el formulario UB04 de instalaciones tales como hospitales y centros quirúrgicos. Contienen la siguiente información requerida:

- Fecha(s) de servicio
- Cargos facturados
- Códigos de diagnóstico: informan qué problema tiene su hijo
- Códigos de procedimiento o ingresos: nos informan qué se hizo para evaluar o tratar el problema
- Número de identificación fiscal del proveedor: necesario para emitir los formularios W-9 cuando se asignan beneficios a proveedores
- Identificador de proveedor nacional (National Provider Identifier, NPI): necesario para cumplir con las regulaciones federales

***NOTA*:** No podemos recibir "resúmenes" de parte de proveedores, Explicaciones de beneficios del plan de salud primario ni recibos de pago en lugar de las facturas detalladas requeridas según se describió anteriormente.

**Si usted tiene Kaiser, solicite "resúmenes de cortesía" de los Servicios para Miembros de Kaiser que incluyan la información mencionada anteriormente. Asegúrese de que la documentación presentada indique qué parte de los cargos, si los hubiere, está obligado a pagar de su propio bolsillo.*

Pasos finales

Envíe: 1) Formulario de reclamo completo; 2) Facturas detalladas; 3) EOB de otro seguro o plan de salud (cuando corresponda) a:

MYERS-STEVENS & TOOHEY
Atención: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

O **Fax: (949) 348-9350** *O* **Correo electrónico: claimsinfo@myers-stevens.com**

¿Necesita más ayuda? Llámenos al (800) 827-4695

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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