Documents Needed to **Start** a Claim

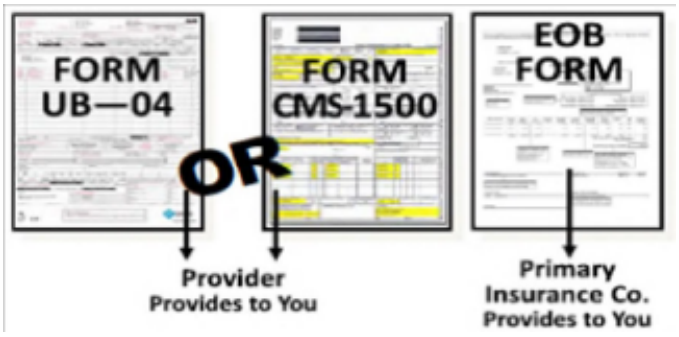
Claim Form: Must be submitted by the college with complete details surrounding the injury. The claim form should be submitted as soon as possible. However, there is a 90 day grace period.

HIPAA Form: Must be submitted with every completed claim form so that anyone at the college or Student Insurance can assist with treatment arrangements, bills, appointments and any other medical information needs.

These 2 documents must be given to the student and once completed, email to Student Insurance at Claims@studentinsuranceusa.com for processing. If one of the documents is missing, an Account Manager will send an email, or letter requesting the needed information from the student directly. If the student cannot be reached an email will be sent to the college. It is very important to respond and keep the lines of communication open to avoid a claim being denied or sent to collections by a provider.

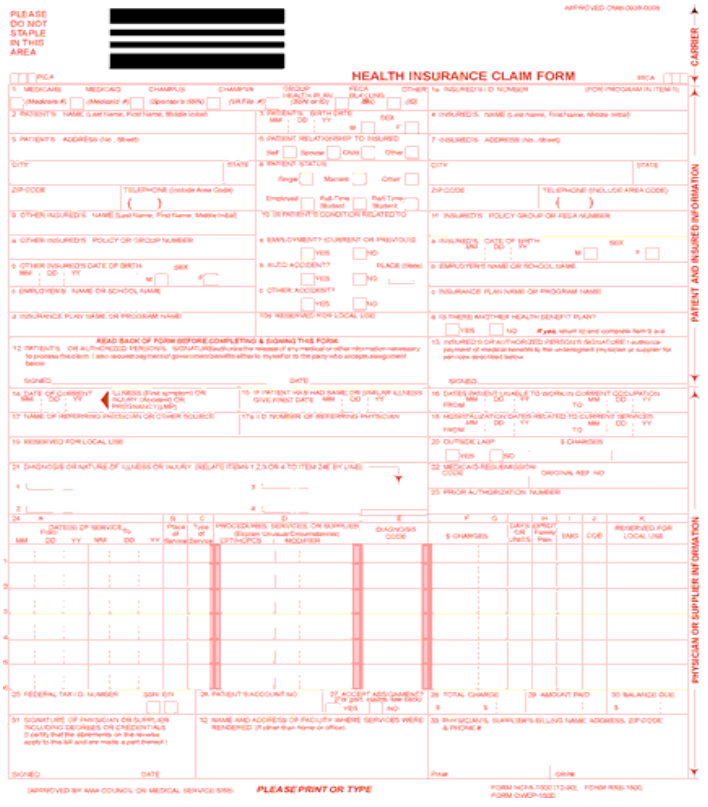
Documents Needed to **Pay** Claims

1. **Fully Itemized Bill:** Typically submitted by health care providers. In some cases, bills will be sent to primary policy holder (student-athlete or parent), in this case send a copy to claims@studentinsuranceusa.com and a Student Insurance Representative will handle it.
   The bill must contain the actual diagnosis codes and amount charged for each treatment. This type of bills are referred to as: **HCFA-1500 for a doctor's report, or UB-04 for a hospital report.**
2. **Balance Due Bill:** A statement or receipt that only shows the amount billed will **NOT** be paid
3. **Explanation of Benefits (EOB):** A summary generated by an insurance company explaining how a claim was processed. It will include the insured's name, date of treatment, amount charged by the provider, the amounts covered and not covered under the insurance plan, and possibly an amount that the student/patient is responsible for.



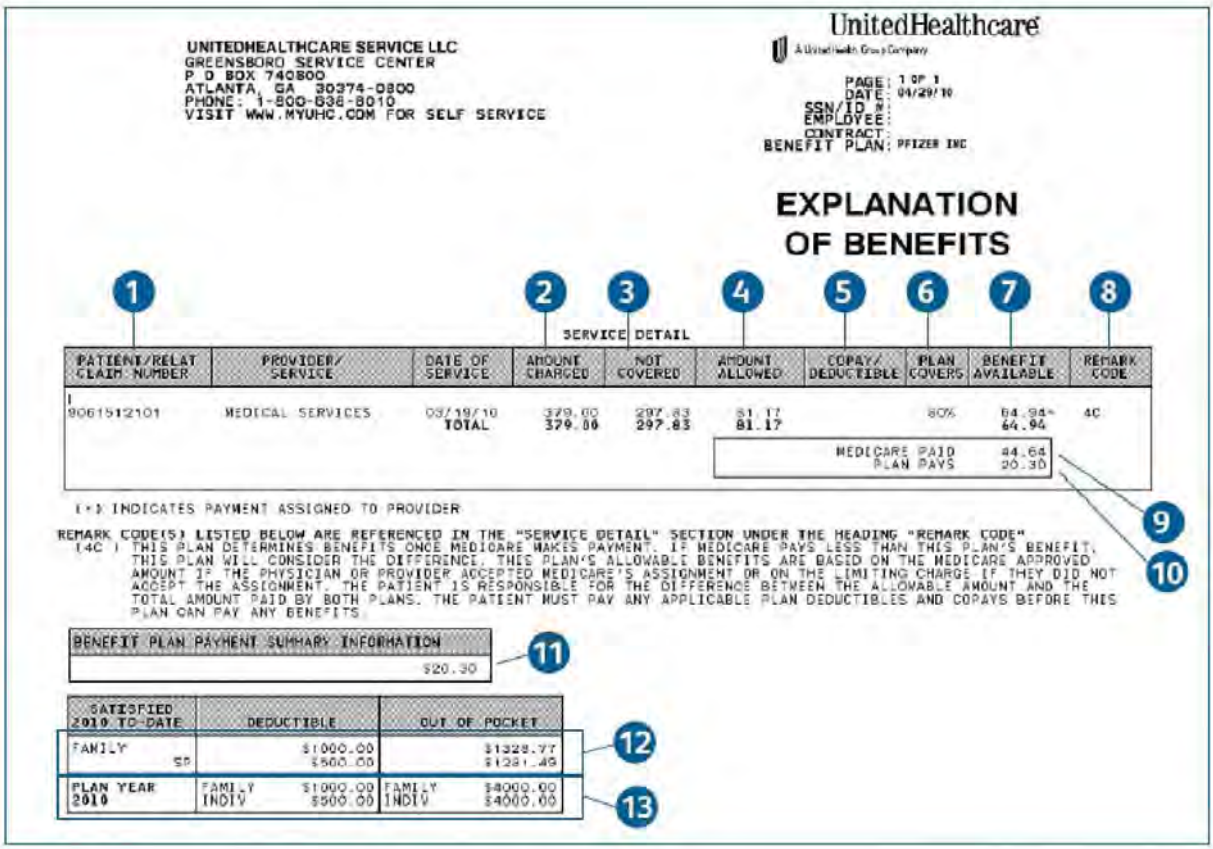
If you receive any bills, email them to claims@studentinsuranceusa.com

SAMPLE HCFA 1500



SAMPLE UB-04

SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	2 DATE OF SERVICE	3 AMOUNT CHARGED	NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
I 9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE		OUT OF POCKET	
FAMILY	$1000.00		$1328.77	
SP	$500.00		$1281.46	
PLAN YEAR 2010	FAMILY	$1000.00	FAMILY	$4000.00
	INDIV	$500.00	INDIV	$4000.00

Understanding Claims Filing

Primary Insurance

A primary policy is coverage that a parent may have through their place of employment, or a policy purchased on the Affordable Care Act exchange, and in some cases a medical health insurance plan provided by the school. These are all considered "primary," This means injuries that occur at the college, at a supervised college event, or during a sport activity will first be handled through that primary insurance.

However, there are certain types of insurance that have limitations, especially when it comes to intercollegiate sports injuries. This is why you must provide all insurance information regardless what it may or may not cover.

NOT Primary Insurance

- Government-Sponsored Insurance (TriCare, Medicaid, etc.): These plans do not pay as primary insurance when the school has accident insurance.
- Student Health Insurance Plan (SHIP): SHIPs may specifically state that injuries related to intercollegiate athletics are not covered. All other injuries may be paid as primary.
- "Religious Ministry" Plans: Ministry plans often exclude intercollegiate athletics, or rely on a discretionary claim process, coverage may not meet institution primary insurance requirements.

School Sponsored Accident Coverage

In the cases, of no primary insurance, the student/athlete accident insurance policy will pay as primary for accident related injuries, within the limits of coverage under the schools policy. The institutions accident policy is for all students including intercollegiate sports.

This is an "accident-only" plan, meaning that illnesses are not covered.

The Axis policy provides payment at 100% of usual and customary charges

How to File a Medical Claim

(For Student, Athletic, and Special Risk Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

Co-ordinated Benefit Plans, on behalf of AXIS Insurance Company
P.O. Box 20874, Tampa, FL 33622
Phone: 866-669-7577 Fax: 800-561-8084
Email:AXISClaims@CBPINSURE.COM

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail or by email.**

The Participating Organization (not the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement and sign the form where indicated in Part I.

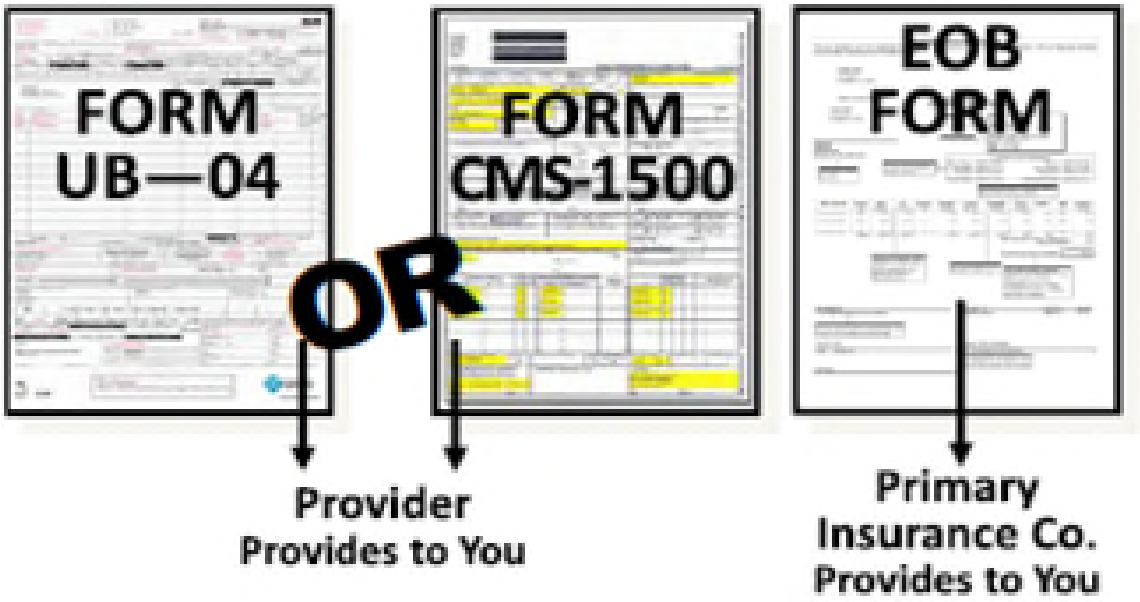
The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on and sign where indicated on the bottom of the Claim Form.

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an Insurance company is not an admission of coverage
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges – examples below).
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.



Co-ordinated Benefit Plans, on behalf of AXIS Insurance Company
P.O. Box 20874, Tampa, FL 33622
Phone: 866-669-7577 Fax: 800-561-8084
Email:AXISClaims@CBPINSURE.COM

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	**Policyholder/Organization/School District Name:**		**Event, Activity or Sport:**	
Name of School/Team/Club/Other:	**Street Address**	**City**	**State**	**Zip Code**
Claimant's Name (Injured Person)	**Social Security Number**	**Gender** ☐ M ☐ F	**Date of Birth**	**E-Mail Address**

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	**Place where Accident Occurred**	**The injured person was a:** ☐ Participant ☐ Staff Member ☐ Other
Dental Claims	**Indicate which Teeth were Involved in the Accident**	**Describe Condition of Injured Teeth Prior to Accident:** ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)		**Did Injury Result in Death?** ☐ YES ☐ NO

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐ YES ☐ NO
B. On activity premises? ☐ YES ☐ NO
C. While traveling directly and uninterruptedly to or from the activity? ☐ YES ☐ NO
D. During a participating organization practice? ☐ YES ☐ NO or competition? ☐ YES ☐ NO

Signature of Participating Organization Representative	**Name and Title of Representative**	**Date**

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other ? YES ☐ NO ☐

If Yes, name of insurance company: _____ **Policy #:** _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicaid?

☐ YES ☐ NO If yes, please explain: _____

IF OTHER INSURANCE EXISTS, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***Co-Ordinated Benefit Plans, on behalf of AXIS Insurance Company*** or its designated administrator**.** This authorization shall remain valid for a period of two years from the date signed. A photo static copy of this authorization shall be considered as effective and valid as the original. A copy of the authorization is available upon request of the company.

I agree that should it be determined, at a later date, there is other insurance (or similar), to reimburse ***Co-Ordinated Benefit Plans, on behalf of AXIS Insurance Company*** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ **DATE** _____