S.A.I.N.
Student & Athlete Insurance Network

HIPAA Individual Authorization

Anthem

Instructions: Please complete the form in its entirety and include as much information as possible.

Individual last name	First name		M.I.	Group ID no.
College name	Social Security no. (optional)	Date of birth (MMDDYY)	Daytime phone no. (with area code)	
Individual street address	City		State	ZIP code

Part A: I authorize the following person or types of people to disclose my information:

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates and agents.

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

S.A.I.N. Health Group plan representatives

Athletic Dept, Risk Management and/or Health Services Personnel.

Chief Business Official and/or Administrator

Name of other authorized person: _____

Part C: I authorize the following information to be used or disclosed on my behalf:
Only limited information may be disclosed (check all applicable blocks below):

Limited Information:
- ☑ Benefits & coverage
- ☑ Billing
- ☑ Claims & payment
- ☑ Diagnosis & procedure
- ☑ Eligibility & enrollment
- ☑ Medical records (excludes psychotherapy notes[1])
- ☑ Physician & hospital
- ☑ Treatment
- ☑ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all blocks that apply to you):

☐ All sensitive information **OR** Just information about topics checked below:

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse[2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request

☐ For the following purposes: **Auditing, enrollment, billing, financial analysis, stop-loss/reinsurance, and benefit analysis.**

Part E: Expiration date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- The date my coverage ends (only if disclosure requested by insurance company)
- One year from the signature date below
- Upon the following date, event or condition (within the one year time frame): _____ (MMDDYY)
- Accident date: _____ (MMDDYY)

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, enrollment, or eligibility for benefits on signing this authorization.
I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Individual signature	Date (MMDDYY)
X	

Designated legal representative/guardian
If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name)	Legal relationship to individual

Individual signature	Date (MMDDYY)
X	

1 Note: This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.

2 I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please keep a copy of this form for your records and return the completed form to:
Student Insurance Email to: claims@studentinsuranceusa.com Phone: 310-826-5688 Fax to: 310-826-1601

Corporate Privacy has approved this form and it is an accepted HIPAA Authorization for the S.A.I.N. (Student Athlete Insurance Network) Group. 6/2023

Student & Athlete Insurance Network Accident Claim Verification Form

Claim control no. for Anthem Blue Cross use only

Providers mail with bills to:
Student Health Claims Dept.
Attn: Claims Manager
21215 Burbank Blvd.
Woodland Hills, CA 91367
Reference S.A.I.N. Program when calling toll free: 866-811-7946
For priority issues please fax to: 855-396-8418

Anthem

This policy is secondary coverage to all other policies, except as required by state or federal law.

To be completed by student or athlete

Student last name	First name	M.I.	Birthdate (MMDDYY)

Street address	City	State	ZIP code

Phone no.	Email address

1. Give full description of injury from which you are now suffering. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred.
Date: ____ (MMDDYY) Time: _____ ☐ a.m. ☐ p.m.

3. When did you first consult a physician for this condition?
Date: ____ (MMDDYY)

4. Do you have other insurance? ☐ Yes ☐ No If yes, complete the following.
Other insurance coverage is through: ☐ Parent ☐ Self ☐ Spouse
Type of coverage: ☐ Individual ☐ Through employer
Type of plan: ☐ HMO ☐ Other: _____
Group/policy no.: _____
Policyholder name: _____
Employer name (if applicable): _____
Insurance company name: _____
Insurance company address: _____

5. Are you an international student?
☐ Yes ☐ No

Sign your full name X	Date (MMDDYY)

On-Campus accidents — To be completed by college official

College name	Group/policy no.	Time classes/activity began on date of injury: Time: _____ ☐ a.m. ☐ p.m.

Did accident occur (check yes or no)	Yes	No		Yes	No
a. While claimant was supervised?	☐	☐	e. During intercollegiate practice?	☐	☐
b. During sponsored activity?	☐	☐	f. During intercollegiate competition?	☐	☐
c. During programmed hours?	☐	☐	g. While traveling to or from a regularly scheduled activity in a supervised group?	☐	☐
d. On school premises?	☐	☐			

I hereby certify that the statements made above are correct to the best of my knowledge and belief and that the above named claimant was insured hereunder at the time of the accident.

College official signature X	Printed name	Title	Date (MMDDYY)

Intercollegiate athletic accidents — To be completed by athletic official

Intercollegiate sport name	Position played	Did injury occur during non-traditional sports session? ☐ Yes ☐ No	☐ Practice ☐ Competition

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision on: → Date (MMDDYY)

Athletic official signature X	Printed name	Title	Date (MMDDYY)

Athletic and on campus accidents — To be completed by college official

Name of class or P.E.: _____

Authorization to pay benefits to provider

I authorize payment of medical payments to physician or supplier for services described for the attached statements:

Student/athlete signature X	Date (MMDDYY)

To the student

- Use this form each time you visit a physician or hospital as a result of an accidental injury incurred while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **ONLY** use this form after the college has properly authorized and completed their portion.
- Give this form to the physician or hospital so they may properly submit the claim to Anthem Blue Cross.
- Copay Reimbursement — may be considered **only if** (1) a HCFA 1500 billing or UB-04 billing is submitted with a copy of the primary insurance Explanation of Benefits (EOB), and (2) a receipt indicating the amount of the copay. Balance due bills or statements are not acceptable documents for processing of payments.

To the provider

- This plan covers the student for accidental injury while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **Please check to see that the appropriate college representatives have completed their portion before submitting the claim.**
- To insure prompt payment, please attach all (UB-04 and/or HCFA 1500) billings to this form and submit to:

  Student Health Claims Dept.
  Attn: Claims Manager
  21215 Burbank Blvd.
  Woodland Hills, CA 91367

  Reference S.A.I.N. Program when calling toll free: 866–811–7946
  For priority issues please fax to: 855–396–8418

Balance due bills or statements are not acceptable documents for processing of payments.

- Electronic Billing is not an option with this program. This program does not accept 'Electronic Billing.' All bills must be submitted via USPS with a copy of the Claim Form attached.
- **Colleges send HIPAA and Claim Forms to:**
  Student Insurance
  Email to: **claims@studentinsuranceusa.com**
  Fax: 310-826-1601
- For additional information, please contact Student Insurance Information at 310-826-5688 or Anthem Blue Cross at 866-811-7946.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.