# 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. |
|---|---|---|---|
| | | | 1842ZA |

| College name | Social Security no. (optional) | Date of birth (MMDDYY) | Daytime phone no. (with area code) |
|---|---|---|---|
| Coast CCD (Golden West College) | | | |

| 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: Information that can be released

I allow the following information to be used or released by Anthem Blue Cross and Blue Shield (Anthem) on my behalf:

**Check only one box.**

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

**OR**

■ **Only limited information** may be released (check all the boxes below that apply to you).

- ■ Appeal
- ■ Benefits and coverage
- ■ Billing
- ■ Claims and payment
- ■ Doctor and hospital
- ☐ Diagnosis (name of illness or condition) and procedure (treatment):_____
- ■ Eligibility and enrollment
- ☐ Financial
- ■ Medical records
- ■ Pre-certification and preauthorization (for treatment approvals)
- ■ Referral
- ■ Treatment
- ☐ Dental
- ☐ Vision
- ■ Pharmacy

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

☐ **All sensitive information**[2]

**OR**

☐ **Just sensitive information about topics checked below**

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health[3] (including abortion, maternity, etc)

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder 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 in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but is not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

**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.

Reset Form Save and Print

**Please keep a copy of this form for your records and return the completed form to:**
**Anthem Email to: SAIN@anthem.com Phone: 866-811-7946**

Corporate Privacy has approved this form and it is an accepted HIPAA Authorization for the S.A.I.N. (Student Athlete Insurance Network) Group. 8/2025


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# Student & Athlete Insurance Network Accident Claim Verification Form

Claim control no. for Anthem Blue Cross use only

Providers send with bills to:
SAIN@anthem.com or mail 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

## To be completed by student or athlete

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

| 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 | Date (MMDDYY) |
|---|---|
| X | |

## On-Campus accidents — To be completed by college official

| College name | Group/policy no. | Time classes/activity began on date of injury: |
|---|---|---|
| Coast CCD (Golden West College) | 1842ZA | 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 | Printed name | Title | Date (MMDDYY) |
|---|---|---|---|
| X | | | |

## 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 | Printed name | Title | Date (MMDDYY) |
|---|---|---|---|
| X | | | |

## 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 | Date (MMDDYY) |
|---|---|
| X | |





Reset Form Save and Print

## 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:
  SAIN@anthem.com or mail 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

- **If Applicable:** The student will present a copy of their ID card, claims may be submitted electronically using the ID number located on the front of the ID card. If you do not already have a process for electronically submitting claims, you may initiate this process by registering and logging into Availity at: www.availity.com.
- For additional information, please contact Anthem Blue Cross at 866-811-7946 or Student Insurance Information at 310-826-5688.

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.