

SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school-related injuries to the school within 72 hours
2. Complete this form
3. Attach all bills
4. Mail to



Myers-Stevens & Toohey & Co., Inc.
 26101 marguerite parkway
 mission viejo, california 92692-3203
 office (800) 827-4695 • fax (949) 348-2630

STUDENT INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (PARENT OR LEGAL GUARDIAN MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)

NAME OF INSURED PERSON			FIRST	MI	LAST	STUDENT I.D. # FROM I.D. CARD		
NAME OF SCHOOL		NAME OF SCHOOL DISTRICT			AGE	GRADE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH MO / DAY / YR
ADDRESS OF SCHOOL				CITY		STATE	ZIP CODE	
DATE OF INJURY/SICKNESS MO / DAY / YR		TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)		INJURY OCCURRED: <input type="checkbox"/> Interscholastic Practice <input type="checkbox"/> Interscholastic Game <input type="checkbox"/> P.E. <input type="checkbox"/> Classroom <input type="checkbox"/> Travel PLEASE <input checked="" type="checkbox"/> ONE <input type="checkbox"/> At Home <input type="checkbox"/> Field Trip <input type="checkbox"/> Other _____				TYPE OF SPORT
DETAILS OF SICKNESS OR HOW THE INJURY OCCURRED. PLEASE BE SPECIFIC						WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) <input type="checkbox"/> YES <input type="checkbox"/> NO		
WHAT PART OF THE BODY WAS INJURED?			HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN?					
NAME AND TITLE OF SCHOOL SUPERVISOR				WAS HE/SHE A WITNESS TO THE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE SCHOOL WAS NOTIFIED OF ACCIDENT		
NAME OF SCHOOL OFFICIAL			SIGNATURE OF SCHOOL OFFICIAL X			DATE SIGNED	SCHOOL TELEPHONE NO. ()	

PART B PARENT OR LEGAL GUARDIAN STATEMENT (PLEASE PRINT OR TYPE CLEARLY)

IS THIS STUDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, NAME OF ORGANIZATION (S)			
NAME OF FATHER OR LEGAL MALE GUARDIAN		DATE OF BIRTH OF FATHER OR LEGAL MALE GUARDIAN	HOME TELEPHONE NO. ()
ADDRESS		CITY	STATE ZIP CODE
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed		WORK TELEPHONE AND EXTENSION NO. ()	
ADDRESS OF EMPLOYER		CITY	STATE ZIP CODE
NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR LEGAL MALE GUARDIAN		POLICY NUMBER	TELEPHONE NO. ()
MAILING ADDRESS OF INSURANCE COMPANY		CITY	STATE ZIP CODE
NAME, ADDRESS AND PHONE NO. OF STUDENT'S FAMILY PHYSICIAN		CITY	STATE ZIP CODE TELEPHONE NO. ()
NAME OF MOTHER OR LEGAL FEMALE GUARDIAN		DATE OF BIRTH OF MOTHER OR LEGAL FEMALE GUARDIAN	HOME TELEPHONE NO. ()
ADDRESS		CITY	STATE ZIP CODE
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed		WORK TELEPHONE AND EXTENSION NO. ()	
ADDRESS OF EMPLOYER		CITY	STATE ZIP CODE
NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY OF MOTHER OR LEGAL FEMALE GUARDIAN		POLICY NUMBER	TELEPHONE NO. ()
MAILING ADDRESS OF INSURANCE COMPANY		CITY	STATE ZIP CODE

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment. I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.	PARENT OR LEGAL GUARDIAN SIGNATURE X
	RELATIONSHIP TO STUDENT _____ DATE _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____

CLAIM FILING PROCEDURE

- ❶ Report school-related injuries to the school within 72 hours.
- ❷ Have school complete PART A. (Parents or legal guardian may fill out PART A if injury is not school related.)
- ❸ Claimant, parent or guardian complete PART B.
- ❹ **IMPORTANT: Both parts must be completed in full or claim will not be processed.**
- ❺ Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**
- ❻ At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).
- ❼ When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office in a timely fashion to expedite the processing of your claim.
- ❽ If you have any questions, please call our office at 800-827-4695.

NON-DUPLICATION OF BENEFITS: In order to keep premiums as affordable as possible, these plans pay benefits on a non-duplicating basis. This means, if a person is covered by one or more of our plans and by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount.

COMMONLY ASKED QUESTIONS

Q: Do I have to go to a specific doctor or hospital?

A: *No, you can go to the doctor or hospital of your choice. However, if you go to a provider within the provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating provider in your area, call 800-226-5116 or log on to www.myfirsthealth.com. In Washington or Idaho, call 800-823-6935 or log on to: www.fchn.com.*

Q: Do I need to attach a claim form for each bill?

A: *No, only one claim form is required per injury or sickness.*



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First Health®

Underwritten by:



Underwritten by:
 ACE American Insurance Company



First Choice Health

PPO Network

WA, ID

For residents of 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.

For residents of Oregon: WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

For residents of 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.