SEE REVERSE SIDE FOR CLAIM FORM 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, CA 92692-3203
Office (800) 827-4695 • Fax (949) 348-9350

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	AGE	☐ FEMALE ☐ 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: ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel PLEASE CHECK ONE: ☐ AT HOME ☐ FIELD TRIP ☐ 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) ☐ YES ☐ NO
WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT	HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

NAME AND TITLE OF SUPERVISOR/SCHOOL OFFICIAL	WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO	DATE SCHOOL WAS NOTIFIED OF ACCIDENT / /
NAME OF SCHOOL OFFICIAL	SIGNATURE OF SCHOOL OFFICIAL X	DATE SIGNED / SCHOOL TELEPHONE NUMBER ( )

PART B PARENT OR LEGAL GUARDIAN STATEMENT

(PLEASE PRINT OR TYPE CLEARLY)

IS THIS STUDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS?
☐ NO ☐ YES IF YES, NAME OF ORGANIZATION (S)

NAME OF FATHER / LEGAL MALE GUARDIAN	DATE OF BIRTH OF FATHER OR LEGAL MALE GUARDIAN	HOME TELEPHONE NO. ( )
ADDRESS CITY STATE ZIP CODE		

NAME OF EMPLOYER Self Employed Part Time 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 / LEGAL FE MALE GUARDIAN	DATE OF BIRTH OF MOTHER OR LEGAL FEMALE GUARDIAN	HOME TELEPHONE NO. ( )
ADDRESS CITY STATE ZIP CODE		

NAME OF EMPLOYER Self Employed Part Time Unemployed	WORK TELEPHONE AND EXTENSION NO. ( )
ADDRESS OF EMPLOYER CITY STATE ZIP CODE	

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH 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.

CLAIMANT 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

1. Report school-related injuries to the school within 72 hours.
2. Have school complete PART A. (Parents or legal guardian may fill out PART A if injury is not school related.)
3. Claimant, parent or guardian complete PART B.
4. IMPORTANT: Both parts must be completed in full or claim will not be processed.
5. Mail form to our office with all itemized bills within 90 days of the first date of treatment.
6. 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).
7. 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.
8. If you have any questions, please call (800) 827-4695 or email claims@myers-stevens.com

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®

First Choice Health
PPO Network - ***WA, ID***

Underwritten by:
BCS

Underwritten by:
ACE *American Insurance Company*

For your protection California law requires the following to appear on this form. For residents of California: 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 and Alaska: 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 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.

For residents of Washington WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.