K-12 Accident Claim Form

Life Insurance Company of North America
Insurance Company of North America
CIGNA Life Insurance Company of New York

For Office Use Only

Policy Number
Reference Number
Coverage Code

Complete both sides of this form. Attach bills and insurance payment records.
Mail to: Preferred Care
1300 Virginia Drive
Suite 315
Ft. Washington, PA 19034
Telephone: 1-800-222-3085

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. ***For residents of the following states, please see page 3: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

CLAIM FORM INSTRUCTIONS

- **Part I** - Must be completed by school official if accidental injury occurs during a sponsored or supervised activity. If accidental injury does not occur during a sponsored or supervised activity, Part I of claim form should be completed by the claimant - or by the parent or guardian if the claimant is a minor (under 18 years of age).
- **Part II** - Must be completed by the claimant or by the parent or guardian if the claimant is a minor.
- **Part III** - Must be completed by physician or dentist providing treatment or services.
- The claim must be submitted within 90 days from the date of injury and the first expense must be incurred within 30 days from the date of injury.
- Attach itemized bills showing diagnosis, treatment, dates of treatment, and charges with corresponding explanation of benefits statement to this claim form. Forward all additional bills with record of payment from your primary insurance.
- Please note the name of the school district on all bills and correspondence.
- All benefits will be made payable to the physicians and providers involved, unless accompanied by paid receipts.

PART I - SCHOOL REPORT

1. Name of School/Address
2. School District
3. Name of Insured Last First Middle Initial
4. Social Security No.
5. Grade
6. Birthdate
7. Sex
8. Nature of Injury (Please describe, fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.)
9. Describe how accident occurred. (Give all possible details.) **MUST BE A BODILY INJURY DUE TO ACCIDENT.**

10. Did Accident occur:

	Yes	No
a) While claimant was school supervised?	☐	☐
b) During school sponsored activity?	☐	☐
c) During programmed school hours?	☐	☐
d) On activity premises?	☐	☐
e) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?	☐	☐
f) Off school premises, at home, during the weekend, holiday, or summer vacation?	☐	☐

11. a) Date of Accident:
 b) Time:
 c) Place:
12. Name of Activity
13. Name and Title of Supervisor
14. Signature of School Officer
15. Title
16. Date

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

PART II - TO BE COMPLETED BY CLAIMANT - OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian
2. Social Security No.
3. Name of Mother or Guardian
4. Social Security No.

5A. Address of Parents or Guardian/or Claimant
5B. Telephone Number

6A. Father or Guardian's Insurance Company Check One: ☐ Individual ☐ Group
6B. Mother or Guardian's Insurance Company Check One: ☐ Individual ☐ Group

7A. Name and Address of Father or Guardian's Employer
7B. Name and Address of Mother or Guardian's Employer

8. List other insurance policies under which claimant is insured:
 a. Company: Policy No. ☐ Individual ☐ Group
 b. Other School Insurance: Policy No. ☐ Individual ☐ Group

9. Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee, or dependent?
 a. Preferred Provider Organization (PPO) or similar health care plan? ☐ Yes ☐ No
 If yes, name of PPO or Organization ____________ Policy No. ____________
 b. Health Maintenance Organization (HMO) or similar prepaid health care plan? ☐ Yes ☐ No
 If yes, name of HMO or Organization ____________ Policy No. ____________

10. If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:
 Name of Insurance Company ____________ Policy No. ____________
 Name of Policyholder ____________

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

Signature (Parent or guardian if claimant is a minor)	Date	Phone No.

PAYMENT AUTHORIZATION - I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature (Parent or guardian if claimant is a minor)	Date

PART III - TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

1. DIAGNOSIS OR NATURE OF INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR ICD-9 CODE.

1.

2.

3.

4.

2. DATE FIRST CONSULTED FOR THIS CONDITION

3. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

4. NAME AND ADDRESS OF REFERRING PHYSICIAN

5. A. DATE OF SERVICE	B. PLACE OF SERVICE ★	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (Identify:)	(Explain unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES

9. YOUR PATIENT'S ACCOUNT NUMBER

10. PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING
TAX I.D. # _ _ _ _ _ _ _ _ _ _ _ _

SOC. SEC. #

11. PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS

12. PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER ( )

6. TOTAL CHARGE

7. AMOUNT PAID

8. BALANCE DUE

I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.

13. PHYSICIAN'S OR PROVIDER'S SIGNATURE

14. DATE

★ 1. (H) __ Inpatient Hospital 2. (OH) __ Outpatient Hospital 3. (O) __ Doctor's office 4. (H) __ Patient's Home 5. (PSY) __ Day Care Facility 6. (SNF) __ Night Care Facility 7. (NH) __ Nursing Home 8. (SNF) __ Skilled Nursing Facility 9. Ambulance O. (OL) __ Other Locations A. (IL) __ Independent Laboratory B. Other Medical Facility

TO BE COMPLETED BY ATTENDING DENTIST

1. DENTIST NAME

2. MAILING ADDRESS

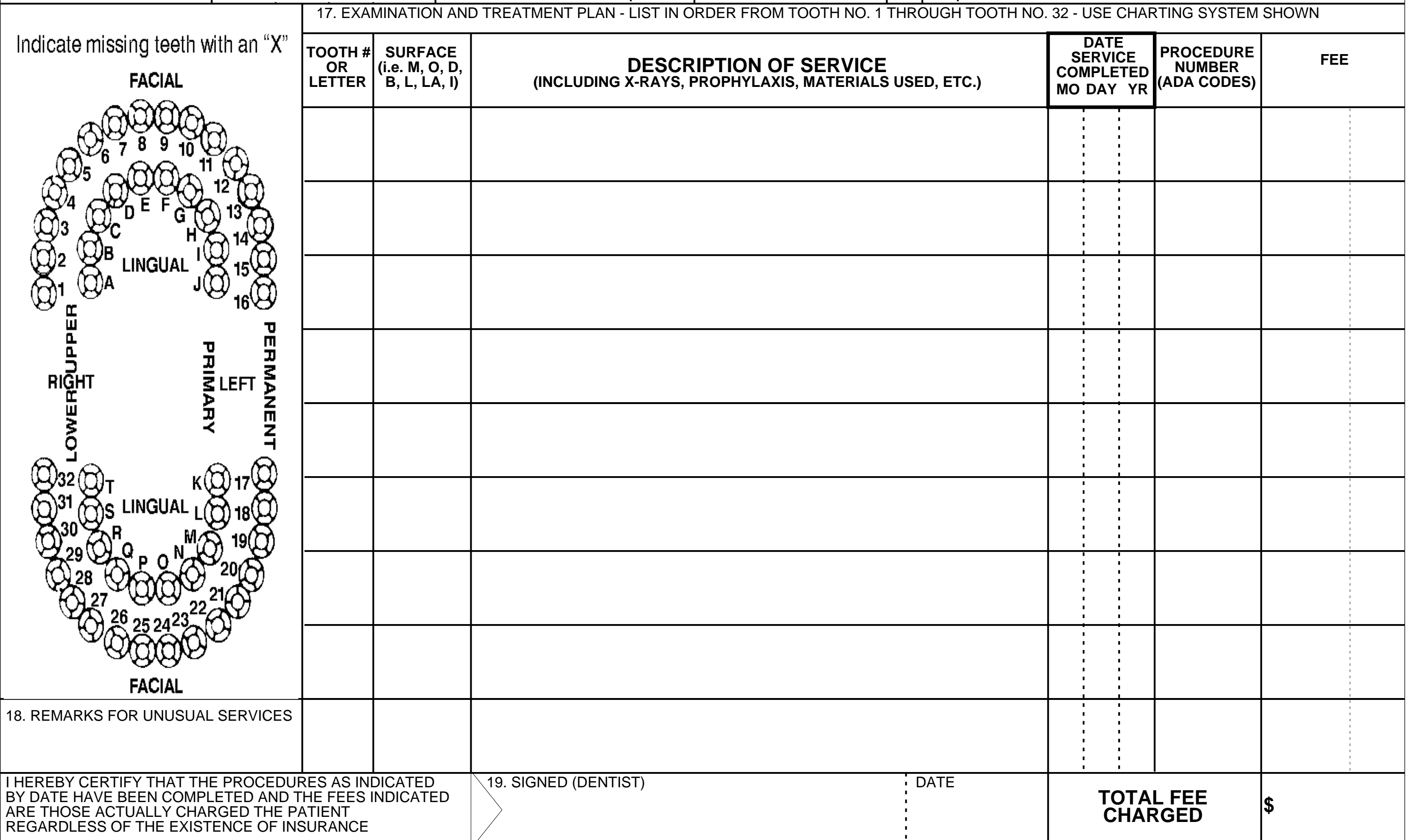
3. CITY, STATE, ZIP

4. TAX I.D. # TO BE USED FOR TAX REPORTING | TAX I.D. | SOC. SEC. #

5. DENTIST LICENSE NO. | 6. DENTIST PHONE NO.

7. FIRST VISIT DATE CURRENT SERIES | 8. PLACE OF TREATMENT OFFICE HOSP ECF OTHER | 9. RADIOGRAPHS OR MODELS ENCLOSED? NO YES | HOW MANY?

	NO	YES	
10. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
11. IS TREATMENT RESULT OF AUTO ACCIDENT?			
12. OTHER ACCIDENT?			
13. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, NAME OF OTHER PLAN:
14. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 16. DATE OF PRIOR REPLACEMENT
15. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING



17. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e. M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED MO DAY YR	PROCEDURE NUMBER (ADA CODES)	FEE

18. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE

19. SIGNED (DENTIST) | DATE

TOTAL FEE CHARGED $

IMPORTANT CLAIM NOTICE

California Residents: Any person who knowingly presents a 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.

Colorado Residents: 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.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: 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 any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information ; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, 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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: 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.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and my be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.