

Student Claim Form UnitedHealthcare StudentResources P.O. Box 809027 Dallas, TX 75380-9027 (888) 251-6160	School District: _____ City and State: _____ School Name: _____ Policy Number: _____
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Student's Last Name _____
Student's First Name _____
Student's Nickname _____
(If Applicable)
Date of Birth _____
Grade _____

Name of Parent/ Legal Guardian		Address Street/ PO Box	
City	State	Zip Code	

WHAT OTHER INSURANCE COMPANY/COMPANIES PROVIDE COVERAGE THAT WOULD COVER THIS CLAIM?

Name of Company(s) _____ **Name of Insured** _____
If NO Other Insurance, Sign Here _____

STATEMENT BELOW MUST BE SIGNED WHEN TREATMENT REQUIRES SURGERY OR HOSPITAL CONFINEMENT.

I hereby authorize the hospital or doctors involved to give UnitedHealthcare StudentResources all information regarding the insured's condition, including the history obtained, findings and diagnosis. A photocopy of this form shall be considered as valid as the original.

Date _____ **Signature of Parent or Legal Guardian** _____

I authorize payment directly to my medical provider(s) for charges for this claim. I understand that I am financially responsible for all charges not covered by this authorization.

Date _____ **Signature of Parent or Legal Guardian** _____

DESCRIBE ACCIDENT/ILLNESS IN DETAIL

Date of Injury _____ **Time of Injury** _____ (AM) (PM) **Date of First Treatment** _____
Place of Injury _____ **Name of Person Supervising the Activity** _____
Which Best Describes the Activity:
 P.E Class
 Athletic Period
 On School Property during
 During Lunch Hr
 School Sponsored Activity
during school hours
 Not School Related
 A Spectator
 Traveling to/from school
 In School Bus
 School Sponsored Field Trip

Describe how injury happened or the nature of an illness? _____

If engaged in an Interscholastic Sport at the time of the injury, what was the sport? _____

What part of the body was injured? _____

REPORTS OF AT-SCHOOL OR ATHLETIC INJURIES MUST BE CERTIFIED BY A SCHOOL OFFICIAL

I hereby certify that the above named student was insured under the UnitedHealthcare StudentResources Plan at the time of the accident and I believe the accident occurred as stated herein.

Date _____ **Parent or Legal Guardian** _____ **School Official** _____

TO ASSURE TIMELY PROCESSING OF YOUR CLAIM, PLEASE VERIFY ALL THE QUESTIONS ABOVE ARE ANSWERED. ATTACH ITEMIZED BILLS, PAID RECEIPTS, EXPLANATIONS OF BENEFITS, AND ALL RELEVANT DOCUMENTS TO THIS CLAIM FORM.

THE FOLLOWING NOTICE IS APPLICABLE TO ANY STATE NOT INDIVIDUALLY LISTED BELOW

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL PENALTIES.

AK - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA – For your protection California law requires the following to appear on this form. 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.

CO – 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.

DE – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC – 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.

FL - 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.

ID – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

IN – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY - 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.

LA - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance*is guilty of a crime and may be subject to fines and confinement in prison.

ME - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NH – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY - 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 five thousand dollars and the stated value of the claim for each such violation.

OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA - 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.

TN - 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.

TX – 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.

VA - 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.

HOW TO FILE A CLAIM FORM

THIS CLAIM FORM MUST BE SENT WITHIN 90 DAYS OF THE DATE YOU FIRST RECEIVED MEDICAL CARE. IF YOU DID NOT SIGN THE REVERSE SIDE TO PAY BENEFITS TO PROVIDER, YOU MUST INCLUDE ORIGINAL RECEIPTS FOR EACH PAID BILL. KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

PLEASE FOLLOW THESE INSTRUCTIONS:

1. All lines must be completely filled out and be sure to sign the Medical Authorization.
2. Send **ORIGINAL ITEMIZED BILLS** with diagnosis and the corresponding **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**. (Keep copies for your records) **BALANCE FORWARD STATEMENTS ARE NOT SUFFICIENT**.
3. Mail completed form to: UnitedHealthcare **StudentResources**, P. O. Box 809027, Dallas, TX 75380-9027.
4. Attach itemized bill to completed claim form. An itemized bill must include:
 - a. School District name
 - b. Patient's name
 - c. Patient's complete address
 - d. Diagnosis
 - e. Date of service(s)
 - f. Description of treatment (i.e. type of x-ray, office visit, lab test, etc.). Including CPT (procedure) codes
 - g. Doctor's/Hospital name, address and telephone number
5. Please do not send bills without a completed claim form. The bills will not be processed with partial information.