

**STUDENT ACCIDENT INSURANCE CLAIM REPORT**

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE COMPANY WITHIN 90 DAYS FROM DATE OF ACCIDENT. MEDICAL TREATMENT MUST COMMENCE WITHIN 30 DAYS FROM DATE OF ACCIDENT.

**IMPORTANT NOTICE:** Your student insurance plan is designed to provide maximum benefits for minimum premium. If your claim is over \$100.00 and you do have other medical coverage, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us with your claim. Benefits will be paid for those eligible expenses not paid by your other insurance.

**INSTRUCTIONS:**

- 1. If accident occurred during a school activity a school official must complete PART 1-A. 2. The insured's parents or guardian must complete PART 1-B; (also PART 1-A if accident was not school related). 3. Sent completed claim form with all itemized bills to:

**LAWRENCE E. SMITH & ASSOCIATES,** Box 411216, St. Louis, Missouri 63141 (636) 532-1660 or 1-800-325-1350

IF PART 1-A, PART 1-B & PART II ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED

(Please type or print)

**PART 1-A: SCHOOL AND PARENT**

- (1) School District \_\_\_\_\_ (2) School \_\_\_\_\_
- (3) School Address \_\_\_\_\_ (4) School Phone No. \_\_\_\_\_
- (5) Student \_\_\_\_\_ (6) Student's Social Security No. \_\_\_\_\_  
(Last Name) (First Name)
- (7) Grade \_\_\_\_\_ (8) Birthdate \_\_\_\_\_ (9)  Male  Female (10) Date of Accident \_\_\_\_\_ (11) Time \_\_\_\_\_
- (12) Where did the accident happen? \_\_\_\_\_
- (13) **Specifically** – what happened? \_\_\_\_\_
- (14) Part of body injured \_\_\_\_\_ (15) Type of sport \_\_\_\_\_
- (16) At the time of injury was the student involved in a school sponsored & supervised activity?  Yes  No  Other \_\_\_\_\_  
If yes, was student a:  participant  spectator
- (17) If athletics, designate:  P.E. Class  Intramural  Interscholastic  Practice  Game
- (18) Under whose supervision? \_\_\_\_\_ Was he/she a witness?  Yes  No
- (19) \_\_\_\_\_  
School Official Signature Title Date

**PART 1-B: PARENT OR GUARDIAN STATEMENT**

- (20) Father's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_
- (21) Mother's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_
- (22) Home Address \_\_\_\_\_  
(Street/P.O. Box) (City) (State) (Zip) (Home Phone No.)
- (23) Father's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Tel. # \_\_\_\_\_
- (24) Employer's Address \_\_\_\_\_
- (25) Name & Address of Insurance Company \_\_\_\_\_
- (26) Policy No. \_\_\_\_\_ Co. Tel # \_\_\_\_\_  Group  Individual  Other  No Other Insurance
- (27) Mother's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Tel. # \_\_\_\_\_
- (28) Employer's Address \_\_\_\_\_
- (29) Name & Address of Insurance Company \_\_\_\_\_
- (30) Policy No. \_\_\_\_\_ Co. Tel. # \_\_\_\_\_  Group  Individual  Other  No Other Insurance
- (31) Name and address of places where treatment was received:  
Doctors: \_\_\_\_\_  
Hospitals: \_\_\_\_\_

Do you understand that you must furnish, with this claim, a statement from your primary insurance company indicating their allowable benefits or their reason for refusal to pay. Your claim will be held pending receipt of this information  Yes  No

**DELAWARE REQUIRED STATEMENT:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **OHIO REQUIRED STATEMENT:** 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. **COLORADO REQUIRED STATEMENT:** 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 CO Div. of Insurance within the Department of Regulatory Agencies. **AFFIDAVIT:** I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, or other organization, institution, or person that has any record or knowledge of: a) the claimant's physical or mental health or: b) benefits for which the claimant may be entitled to for this claim; to give the information to the insurance company to facilitate rapid submission for such information. I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.

**SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

**L. E. SMITH & ASSOC., INC., PLAN ADMINISTRATOR**  
**ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE**

**HEALTH INSURANCE CLAIM – GROUP OR INDIVIDUAL**

Patient's Name	Address	City, State, Zip	Age
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**PART II: ATTENDING PHYSICIAN'S STATEMENT**

1. Diagnosis and concurrent conditions. Describe any complications.

2. When did symptoms first appear or accident happen? Date \_\_\_\_\_

3. When did patient first consult you for this condition? Date \_\_\_\_\_

4. Has patient ever had same or similar condition? If yes, state when and describe. No Yes Date \_\_\_\_\_

5. Describe any other disease or infirmity affecting present condition.

6. If fracture or dislocation, state whether reduced or immobilized. If immobilized, explain procedure. Fee \$ \_\_\_\_\_  
CPT/CRVS \_\_\_\_\_

7. Name of surgical procedure. Describe fully. Include CPT/CRVS Code. Where and when performed? Fee \$ \_\_\_\_\_  
CPT/CRVS \_\_\_\_\_ Date \_\_\_\_\_ Office If in hospital, inpatient outpatient

8. Give dates of other medical (non-surgical) treatment, if any. Describe. CHARGE PER CALL

Office _____	\$ _____
Office _____	\$ _____
Hospital _____	\$ _____
Hospital _____	\$ _____
TOTAL (NON SURGICAL) CHARGES \$ _____	

9. If patient hospitalized, give name and address of hospital. Date admitted \_\_\_\_\_ Date discharged \_\_\_\_\_  
Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

10. To your knowledge does patient have other health insurance or health plan coverage? If "Yes", identify. No Yes  
Name \_\_\_\_\_ Address \_\_\_\_\_

**If Dentistry, answer all questions below, in addition to those above.**

1. State exactly which teeth were involved in the accident and indicate them on chart.

\_\_\_\_\_  
\_\_\_\_\_

2. Describe exact nature of injury \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**2. Describe condition of injured teeth prior to accident:**

Whole, sound and natural Filled Capped/Artificial Caries

4. Comments \_\_\_\_\_

Physician or Supplier's Name	Degree
Street Address	TIN #
City State Zip	Date
Telephone	Signature

**IMPORTANT:** This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by all bills incurred to that date.