Student Accident Claims

Note to all parents with Philadelphia Accident Claim Form
Effective: July 1, 2022

All students within the Diocese of Jefferson City have access to a Student Accident Policy. This policy is a Full Excess Policy meaning if a student (Pre-K thru 12) is injured during school due to an accident it will pay covered medical expenses not covered by the student's individual health insurance, subject to limitations and exclusions **(payment is not guaranteed).** The policy is underwritten by Philadelphia Insurance Company.

In addition to the fully completed Accident Claim Form attached (should be completed within 30 days of incident), Philadelphia will need an itemized billing statement from each of the providers that were seen as a result of the injury (doctors office, hospital, etc). To receive the itemized billing statements, **you must call the hospital or clinic** and ask to speak with a representative in the billing department. The itemized billings go by the code UB-04, UB-92, CMS 1500, CMS 1200, or commonly known as the "HCFA" form. They can mail you a copy. ***Please note that the itemized billing statements are different from the billing statements you normally receive from the provider.*** Philadephia will not accept an invoice for payment - it must be one of the itemized billing statements listed above.

The other item needed is the Explanation of Benefits (EOB) from your current medical insurance company, which shows the charges of each provider, what has been paid, and the balance due. There should be an EOB to match up to each provider's itemized statement. The Diocese student accident policy pays only after your primary medical insurance has paid.

All information should be mailed to the address below within 90 days of the incident. Once we receive this information from you, we will send all the information to Philadelphia for processing. The processing of the claim takes approximately 6-8 weeks once they receive **all** the information needed.

You may contact Mary Baysinger (573-634-2122, x1320, mary.baysinger@winter-dent.com) at Winter-Dent with any questions. The Accident claim form and all itemized billings should be mailed to:

Mary Baysinger
Winter-Dent & Co
PO Box 1046
Jefferson City, MO 65102

WINTER-DENT
100% EMPLOYEE OWNED COMPANY

PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

ACCIDENT CLAIM FORM

MAIL TO: Winter-Dent & Co.
Attn: Mary Baysinger
P O Box 1046
Jefferson City, MO 65102

Questions: Contact 800-769-3472, x 1320

INSTRUCTIONS (SIGNATURE SECTION MUST BE COMPLETED AT THE BOTTOM OF ALL THREE PAGES)

- All fields must be completed
- Part I – Must be completed by Policyholder
- Part II – Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
- Attach explanation of benefits, additional bills with record of payment or denial from primary insurance carrier.This does not apply if the accident policy provides primary coverage
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.
- For additional instructions about how to file a claim, please send an email to **mary.baysinger@winter-dent.com**

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I – POLICYHOLDER REPORT (Signature is required at the end of this section)

1. Policy Number: PHPA110745
2. Name of Policyholder: Diocese of Jefferson City
3. Policyholder Address: 2207 W Main Street
4. City: Jefferson City State: MO Zip: 65109-0914
5. Policyholder Contact: Email: Phone: Fax:
6. Last name of Claimant: First name of Claimant:
7. Social Security Number: Date of Birth:
8. Sex: ☐ Male ☐ Female
9. Grade (if applicable): Check one (if applicable) ☐ Day School ☐ Boarding
10. Nature of injury: **(Describe, fully indicate what part of the body was injured – e.g. broken arm, sprained ankle) Must be a bodily injury due to accident.**

11. Describe how the accident occurred, provide all details.
Attach a separate sheet, if necessary (include name of sport / activity)

12. Did the accident occur:
    a. During a Policyholder supervised / authorized activity? ☐ Yes ☐ No
    b. During a Policyholder sponsored activity? ☐ Yes ☐ No
    c. During scheduled Policyholder hours? ☐ Yes ☐ No
    d. While traveling to or from a Policyholder sponsored and supervised activity? ☐ Yes ☐ No
    e. Off Policyholder premises, at home, during the weekend, holiday or summer vacation? ☐ Yes ☐ No
13. Date of Accident: Time of Accident: ☐ A.M. ☐ P.M
    Place of Accident:
14. Name and title of person supervising activity:
    Was he or she a witness? ☐ Yes ☐ No

Signature of Authorized Policyholder Representative **Title** **Date**

PART II

(To Be Completed by Claimant or Parent / Guardian, if Claimant is a Minor)

1. Name of Claimant or Father / Guardian: _____
   Social Security Number: _____ Email Address: _____
2. Name of Mother or Guardian: _____
   Social Security Number: _____ Email Address: _____
3. Street address of Claimant or Claimant Parent/ Guardian: _____
   City: _____ State: _____ Zip: _____
   Telephone Number: _____
4. Father or Guardian's Insurance Company: _____
5. Mother or Guardian's Insurance Company: _____
6. Name and address of Claimant or Father / Guardian's employer, if a minor:
   Employer's Name: _____
   Employer's Mailing Address: _____
   City: _____ State: _____ Zip: _____
7. Name and address of Claimant or Mother / Guardian's employer, if a minor:
   Employer's Name: _____
   Employer's Mailing Address: _____
   City: _____ State: _____ Zip: _____
8. List all medical and dental policies under which the Claimant is insured:

Name of Policyholder	Type of Policy	Policy Number

9. Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If yes, please provide a copy of the insurance card (front and back).
   a. Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No
      If yes, name of PPO Organization: _____
   b. Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No
      If yes, name of HMO or organization: _____
   c. Medicare? ☐ Yes ☐ No
   d. Medicaid? ☐ Yes ☐ No

AFFIDAVIT

I verify that the statement on the other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, 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 Philadelphia Indemnity Insurance Company, its employees and authorized agents for the purpose of validation and determining benefits payable. I further authorize any Philadelphia Indemnity Insurance Company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

PAYMENT AUTHORIZATION (Signature is required at the end of this section)

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, unless paid receipts accompany this form.

Claimant Signature (Parent or guardian, if the claimant is a minor) _____ **Date** _____

CLAIM FORM FRAUD STATEMENTS (Signature is required at the end of this section)

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison or any combination thereof.

ARIZONA: 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.

ARKANSAS, RHODE ISLAND AND WEST VIRGINIA: 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.

CALIFORNIA: 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.

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.

DELAWARE and IDAHO: 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.

DISTRICT OF COLUMBIA: 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: 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.

INDIANA: 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.

KANSAS: Any person who, knowing and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: 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.

MAINE, TENNESSEE, VIRGINIA, and WASHINGTON: 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.

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

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defrauds, 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.

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

NORTH CAROLINA and OREGON: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

OHIO: 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.

OKLAHOMA: 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.

PENNSYLVANIA: 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.

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

NEW YORK: 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.

Claimant Signature (Parent or guardian, if the claimant is a minor) _____ Date _____