This form must be returned **to the School Division within 90 days from date of incident**. VACORP will send parents information on submitting bills and EOBs for consideration on applicable claims. *School will not accept bills or EOBs*.

VAcorp

(888) 822-6772

STUDENT ACCIDENT CLAIM FORM

Student Accident Coverage is SECONDARY to any other insurance, including Medicaid, FAMIS, or private health insurance.

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____
School Name: _____
School Address: _____
Student's Name: _____

☐ Male ☐ Female Date of Injury: _____ Date of Birth: _____

Grade Level: _____
Body Part: _____ Diagnosis: _____

Description of Accident (Include an additional page if needed):

_____
_____
_____

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? ☐ Yes ☐ No
Under whose supervision? _____ Phone #: _____
Website Assigned Claim Number: _____

Signature of Preparer: _____ Title: _____
Printed Name: _____ Date: _____ Phone #: _____

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION) *If additional room is needed, please feel free to use another piece of paper*

Student Information:
Student Address: _____ Student SSN: _____-_____-_____

Parent Information:
Father's Name: _____ Phone #: _____
Father's Employer: _____
Employer's Address: _____
Mother's Name: _____ Phone #: _____
Mother's Employer: _____
Employer's Address: _____

Please list **ALL** insurance policies: ☐ Medicare/Medicaid ☐ Check if No Insurance

Name of Insurer: _____
Address: _____ Policy #: _____
Phone #: _____ ☐ Group ☐ Individual HICN (if Medicare): _____
Name of Policyholder: _____

Initial Treating Physician:
Physician/ Facility Name: _____
Address of Physician/ Facility: _____
Phone #: _____ Date Seen By Physician/ Facility: _____

CLAIM INSTRUCTIONS: In case of accident, notify the school immediately.

Student Accident coverage is only available to cover students for accidental injury occurring while Contract is in force.

1. Complete this claim form, sign, and return it to the school division within 90 days from the date of injury. This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed. **If the claim form is submitted to VACORP after 90 days of the date of injury, the claim will not be considered for payment.**
2. All expenses must be incurred and reported to VACORP within a year of the date of accident. Any expenses incurred and/or reported to VACORP more than 365 days after the accident will not be considered for payment.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanation of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will ***not*** be accepted.
4. When you receive an EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the parent/guardian, who must pay the medical provider(s).
6. VACORP will not issue payment on any claim until a Social Security Number and Date of Birth of the claimant is provided per MMSEA guidelines. In Lieu of a SSN, a Medicare Health Insurance Claim Number (HICN) may be submitted.
7. All claims are subject to the terms, conditions and exclusions found in the coverage document. The coverage contract supersedes any contradictory statements contained herein.

Benefits are provided on a ***SECONDARY*** excess basis for covered expenses. Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including, Medicaid, Medicare, FAMIS, and private health insurance. You must follow any requirements for obtaining health care benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the Contract provisions.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize all medical service sources and health care providers to disclose a complete copy of my health records, including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse to Virginia Association of Counties Group Self-Insurance Risk Pool, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as VACORP).

I authorize the use of the above information for VACORP to investigate, process and determine the amount payable, if any, for all claims made under any VACORP property and casualty contract that applies to the accident or occurrence on _____. I understand as part of the claim handling process, VACORP may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professional for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that VACORP has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s). This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and singed this document. I verify that the statement in Part 2 about other insurance is accurate and complete. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract. 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.

Any payment will be made directly to the parent/guardian, who must pay the medical provider(s).

Parent or Authorized Representative's Signature: _____ Date: _____If Authorized Representative, Relationship to Student or Legal Designation: _____