Cusumano Insurance
AGENCY, INC.

SCHOOL CLAIM PROCEDURE
SCHOOL YEAR 2016-2017

Completion of Claim Form

Top Section for School – To be completed and **signed** by a school official. **Please make sure the date of accident is correct.**

Bottom Section for Parent – **Important** – Must be completed in full and **signed** by parent or guardian otherwise claim form will be returned. Please make sure your name, address, and phone number are included. Do not leave any spaces blank.

Reverse Side – Complete the reverse side only for dental claims.

IMPORTANT: **DO NOT** leave claim form at Hospital. **Itemized bills including UB-04, UB-92, HCFA-1450 or CDT codes and Explanation of Benefits** forms from your primary carrier are required. Attach both for each date of service with the completed claim form and forward to the address below. Please sign the authorizations as invoices cannot be requested without your signature.

Additional Bills – **DO NOT** complete a new claim form for additional bills. Please note the name of the School District on any additional bills. All bills must be **itemized** and the **Explanation of Benefits** form must be included for each date and service.

Please Note – This is an **ACCIDENT POLICY**. Claims for sickness, disease, etc. will not be honored. **The athletic insurance is secondary to parents' insurance. IF PARENTS HAVE HMO COVERAGE, HMO PROCEDURES MUST BE FOLLOWED. OUT OF NETWORK SERVICES WILL BE PAID AT 50% OF THE USUAL AND CUSTOMARY FEE SCHEDULE.**

- ***Claim Form Must Be Submitted Within 90 Days from the date of the Injury.*** Attach all itemized bills and send to:

  Goodwin & Gruber Agency
  300 McKnight Park Drive
  Pittsburgh PA 15237
  Phone: (412) 366-5080 Fax: (412) 366-3360

If you have any further questions, please contact our agency.

Joann Cusumano Sciulli

SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **Itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills

GOODWIN & GRUBER AGENCY
300 McKNIGHT PARK DRIVE
PITTSBURGH, PA 15237-6534
(412) 366-5080

Name of School _____ Policy No. _____ Student's Social Security Number

School System _____ Name of Student _____

Student covered: ☐ Schooltime ☐ 24 Hr. ☐ Dental ☐ All Sports ☐ Football Student's Birthdate _____ Grade _____

Name and Address of Parent or Guardian _____

1. Date of Accident _____ Time _____ ☐ AM ☐ PM Phone _____
2. COMPLETE details of accident _____
3. Nature of Injury _____
4. Did accident occur while:
   (a) Attending school during hours and days school in session? ☐ No ☐ Yes ; on Home premises? ☐ No ☐ Yes
   (b) Traveling to or from School? ☐ No ☐ Yes If yes, was student on usual and direct route? ☐ No ☐ Yes
   (c) Engaged in a school sponsored and supervised activity? ☐ No ☐ Yes If yes, name and place of activity _____
   (d) Was student participating in an Intramural (☐ Yes ☐ No) or **Interscholastic** (☐ **Yes** ☐ **No**) sport? What sport? _____
5. Names and addresses of attending physicians _____

I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.

SIGNATURE OF SCHOOL OFFICIAL _____ Title _____ Date _____
(Required on all claims except 24 hour coverage)

SIGNATURE OF PARENT OR GUARDIAN _____ Date _____
(Parent please complete reverse side of claim form)

This Section Must Be Completed by Parent or Guardian

IF BLUE CROSS (HOSPITALIZATION) GROUP # CONTRACT # SERVICE CODE #	IF BLUE SHIELD (PHYSICIAN'S CARE) GROUP # CONTRACT # SERVICE CODE #
NAME AND ADDRESS OF MOTHER'S EMPLOYER	NAME AND ADDRESS OF FATHER'S EMPLOYER

DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS?	IF SO, NAME OF COMPANY	POLICY NUMBER
ADDRESS OF OTHER INSURANCE COMPANY NAMED ABOVE		TYPE OF PLAN FROM THIS COMPANY ☐ Individual ☐ Group

AFFIDAVIT

I verify that the above statement on 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. 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 insurance company named on the reverse side of this form to the extent of any amount collectible.

SIGN: Parent or Guardian _____ Date _____

please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim.

AUTHORIZATION

I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.

Signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.

SIGN: Parent or Guardian _____ Date _____

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.

PHYSICIAN'S OR DENTIST'S REPORT (Required on Dental Claims).

1. Nature of Injury
2. Date of First Treatment _____
3. Has patient ever had the same or similar condition? ☐ No ☐ Yes . If yes, state when and describe _____
4. Nature of Surgical Procedure, if any & procedure code _____
5. Dates of Treatment _____ Description _____ Charge _____

TOTAL

6. Has patient been discharged from treatment? ☐ No ☐ Yes . If yes, give date _____
7. Was patient confined to hospital? ☐ No ☐ Yes . If yes, give name and address of hospital and dates confined _____
8. **TO WHAT OTHER INSURANCE COMPANY HAVE YOU REPORTED THIS CLAIM?** _____
   Name
   Address
9. List below teeth involved and indicate on chart.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

10. Describe Condition of Injured Teeth Prior to Accident.
    1. CARIOUS ☐
    2. FILLED ☐
    3. WHOLE ☐
    4. CAPPED OR ARTIFICIAL ☐
    5. SOUND AND NATURAL ☐

CO. USE ONLY

NOTICE OF A LEGAL REQUIREMENT—Please insert your Tax Identification No. as required by Section 6041 of the Internal Revenue Code.
CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S NAME AND ADDRESS
Name (Please print or type) Address

HOSPITAL REPORT—Attach Itemized Hospital Bill, If Any.

PLEASE ATTACH ITEMIZED BILLS

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