SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school related injuries to the school within 72 hours.
2. Complete this form.
3. Attach all bills
4. Mail to

26101 marguerite parkway
mission viejo, california 92692-3203
(949) 348-0656 • fax (949) 348-2630
License # 0425842

DIOCESE ACCIDENT CLAIM FORM

PLEASE PRINT OR TYPE CLEARLY

PART A SCHOOL/CHURCH STATEMENT *(PARENT MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)*

NAME OF INSURED PERSON FIRST MI LAST | STUDENT SOCIAL SECURITY # — — ◄OR► | STUDENT I.D. # FROM I.D. CARD

NAME OF SCHOOL/CHURCH | NAME OF DIOCESE | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF SCHOOL/CHURCH | CITY | STATE | ZIP CODE

DATE OF INJURY MO / DAY / YR | **TIME OF INJURY** : A.M. / P.M. (CIRCLE ONE) | INJURY OCCURRED: PLEASE ✔ ONE ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ TRAVEL ☐ CLASSROOM ☐ AT HOME ☐ FIELD TRIP/RETREAT ☐ P.E. ☐ OTHER | TYPE OF SPORT

DETAILS ON HOW THE INJURY OCCURRED. **PLEASE BE SPECIFIC** (NOTE: IF YOUR SCHOOL USES AN ACCIDENT REPORT FORM, PLEASE ATTACH A COPY OF THE REPORT ALSO).

WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) ☐ YES ☐ NO

WHAT **PART** OF THE BODY WAS INJURED?

HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

INDICATE IF INJURY WAS RECEIVED DURING PARTICIPATION IN THE FOLLOWING ACTIVITIES, PLEASE CHECK THE APPROPRIATE BOX:

☐ SCHOOL ☐ RELIGIOUS EDUCATION ☐ CONFIRMATION ☐ YOUTH MINISTRIES ☐ YOUNG ADULT MINISTRIES ☐ CYO OTHER ☐ OTHER

NAME OF SCHOOL/CHURCH SUPERVISOR | DATE SCHOOL/CHURCH WAS NOTIFIED OF ACCIDENT | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO

NAME OF SCHOOL/CHURCH OFFICIAL | SIGNATURE OF SCHOOL/CHURCH OFFICIAL X | DATE SIGNED | SCHOOL/CHURCH TELEPHONE NO. ( )

PART B PARENT OR GUARDIAN STATEMENT

RELATIONSHIP TO INJURED ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN ☐ OTHER | IS THIS DEPENDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN? ☐ YES ☐ NO

NAME OF LEGAL MALE GUARDIAN | DOB OF LEGAL MALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH LEGAL MALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME OF LEGAL FEMALE GUARDIAN | DOB OF LEGAL FEMALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH LEGAL FEMALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.

I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

PARENT OR GUARDIAN SIGNATURE X

RELATIONSHIP TO STUDENT | DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CLAIM FILING PROCEDURE

1. Report school related injuries to the school within 72 hours.
2. Have school complete PART A. (Parents may fill out PART A if injury is not school related.)
3. Parent or guardian complete PART B.
4. **IMPORTANT: Both parts must be completed <u>in full</u> or claim will not be processed.**
5. Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**
6. At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).
7. When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office.
8. If you have any questions, please call (800) 827-4695 or email claims@myers-stevens.com

COMMONLY ASKED QUESTIONS

Q: Do I have to go to a specific doctor or hospital?

A: *No, you can go to the doctor or hospital of your choice. However, if you go to a provider within the provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating provider in your area, call 800-226-5116 or log on to <u>www.myfirsthealth.com</u>. In Washington or Idaho, call 800-823-6935 or log on to: <u>www.fchn.com</u>.*

Q: Do I need to attach a claim form for each bill?

A: *No, only one claim form is required per injury or sickness.*

First Health® | First Choice Health PPO Network WA ID | Select NET Plus, Inc. WV | RAN AMN HMN AZ | HN MT

Arranged & Administered By:

myers | stevens | toohey

26101 marguerite parkway
mission viejo, california 92692-3203
(800) 827-4695
fax (949) 348-2630
License # 0425842

Underwritten by:
ACE American Insurance Company

ACE

Underwritten By:

BCS

For residents of California: Any person who knowingly presents 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.
For residents of Oregon: WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud