ISDA Illinois School District Agency

ISDA Student Accident Claims Administrator

2022-2023 STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to ISDA Claims Administrator by the required due dates.

1) Claim Form must be submitted no later than 90 days after the date of injury.

2) Itemized bills must be submitted no later than 90 days after the date of treatment.

3) Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.

#1, #2 & #3 listed above must all be submitted if you have other insurance

INSTRUCTIONS: **PLEASE RETAIN A COPY FOR YOUR FILES**

1. The school official must complete Part A.
2. The Insured's parent/guardian must complete Part B.
3. In case of dental charges, the attending dentist **must** complete the Attending Dentist's Statement on the reverse side of this form.

PART A: NOTICE OF INJURY FROM SCHOOL (Please type or print)

1. Name of School _____ School District Name _____

   School Address _____ _____ _____ _____
   (City) (State) (Zip)

2. School Contact Name _____ School Contact Phone Number _____

3. Name of Student _____

4. Date of Injury _____Time ___:___AM ___:___PM Under whose supervision? _____ Was he/she a witness? _____

5. The injury was incurred while the student was participating in: (*please check*)

INTERSCHOLASTIC SPORTS
( ) Practice
( ) Game
Name of Sport _____

NON-INTERSCHOLASTIC SPORTS – Where did accident occur?
( ) Travel to/from school ( ) Non-school activity
( ) In classroom ( ) Other – Activity?
( ) Physical Education _____
( ) On school grounds ( ) Recess

6. Part of the body injured ( ) Right ( ) Left _____

7. Describe exactly how injury happened (Please be specific) _____
_____

Reported by _____ _____ _____
Signature of School Official Title Date

PART B: STATEMENT FROM PARENT OR GUARDIAN *(Important Information on Reverse Side)* (Please type or print)

1. Name of Parent _____ Relationship to Student _____

   Home Address _____ (_____)_____
   Home Phone Number
   _____ _____ _____ (_____)_____
   City State Zip Cell Phone Number

2. Father's Occupation _____ Employer _____ _____
   Phone Number

3. Mother's Occupation _____ Employer _____ _____
   Phone Number

4. Student's Date of Birth _____ Grade _____ M / F Student's Social Security Number _____

5. **THIS AREA MUST BE COMPLETED**, Is student covered under any other insurance plan? Yes ____ No ____ List all other insurance coverage in force

   Name of Insurance Company _____ Group ____ Individual _____ Policy #_____

   Phone Number (_____)_____ Whose insurance is it? ( ) Mother ( ) Father ( ) Guardian

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to ISDA Claims Administrator. To facilitate rapid submission of 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. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim.

_____ _____ _____
Date Print Name of Student Signature of Parent or Guardian

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested on this form may upon conviction be subject to fine or imprisonment.*

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PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

- **Complete and submit the Claim Form to ISDA Claims Administrator no later than 90 days after the date of injury.**
- Students must be treated by a licensed medical or dental provider **within 30 days** after the date of the covered injury**.**
- **DO NOT** leave this Claim Form with the physician or hospital**.**
- Review the Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. The brochure is available at www.wcsit-isda.com/sa. An identification card is included in the brochure. Please cut out the ID card and carry it with you. It should be presented to the hospital, Doctor and Dentist along with your primary insurance ID card (if applicable) whenever you seek medical/dental attention for a school related injury.
- A school official must complete Part A for all school-related injuries. The parent or guardian must complete **all** questions in Part B – Statement from Parent or Guardian.
- **Itemized bills** must be submitted to ISDA Claims Administrator **no later than 90 days** after the date of treatment**.** All bills must include the diagnosis and procedure codes.
- Please remember that this plan is **EXCESS** to all other valid coverages. If you have other insurance, you **MUST** file a claim with your primary insurance carrier first, even if you have a large deductible. You should not wait until you have all the bills and EOBs because you may miss a due date.
- When you receive the **Explanation of Benefits (EOB)** from your primary insurance carrier or claims administrator, send them to ISDA Claims Administrator **no later than 180 days** after the date of treatment.
- All documents should be sent to the following address within the **required time frames**: Student Accident Claims, ISDA Claims Administrator, 333 West Wacker, Suite 1200, Chicago, IL 60606 or faxed to (312) 930-7232.
- For additional questions, please call (800) 419-3206 or (312) 930-6143.

ATTENDING DENTIST'S STATEMENT

1. Date of Injury_____ 2. If Prosthesis, is this initial placement?_____
3. Were the teeth sound or natural prior to the current treatment? _____YES _____NO
4. Are any services covered by another plan? If so name plan? _____YES _____NO

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

_____ _____
Print Dentist's Name Dentist Signature

_____ _____
Street Address Date

_____ _____
City State Zip Telephone

_____ Federal tax ID Number (must be included)