Claim Kit

STUDENT ACCIDENT COVERAGE

How to File a Claim

CLAIM FORM

- **Complete and submit the Claim Form to ISDA Claims Administrator no later than 90 days after the date of injury.** You should not wait until you have all the bills and Explanation of Benefits because you may miss a due date.

- **DO NOT** leave the Claim Form with the physician or hospital.

- A school official must complete the Claim Form. Do not leave any blank spaces or write "N/A" in any space.

ITEMIZED BILLS

- **Itemized bills must be submitted to ISDA Claims Administrator immediately as you receive them, but no later than 90 days after the date of treatment.** Itemized bills include (1) CMS-1500 (physician/ancillary charges) and (2) UB04 (hospital charges). All bills must include patient's name, date of service, total charge, procedure and diagnosis codes.
- If you already paid the bill(s), include the receipt or a copy of your cancelled check. Payment will be made to the provider(s) of service (hospital, physician, radiologist, etc.) unless a paid receipt or statement from the provider accompanies the itemized bill showing the bill was paid.

EXPLANATION OF BENEFITS (EOB)

- Your medical/dental provider must submit the bills to your primary insurance carrier first. You will receive an Explanation of Benefits (EOB) from your primary insurance carrier or claims administrator (Blue Cross, Group Health, Prudential Insurance, etc.) after they have processed your claim. **EOBs should be submitted to ISDA Claims Administrator immediately as you receive them, but no later than 180 days after the date of treatment.** Your claim will be held pending receipt of this information.

GENERAL INFORMATION

- Send claim documents to the following address within the required time frames stated above.

Student Accident Claims
ISDA Claims Administrator
333 West Wacker, Suite 1200
Chicago, IL 60606

Telephone: (800) 419-3206 or (312) 930-6165 Facsimile: (312) 930-7232

- Benefits will not be paid unless you submit itemized bills and Explanation of Benefits, if you have other insurance, and they are submitted within the required time frames.

- Benefits under the Student Accident Coverage Plan are not guaranteed. Upon our receipt of acceptable, complete and timely claim documentation, benefits will be determined in accordance with the terms and conditions of the Plan of Coverage.

- 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. This ID Card should be presented to the hospital, Doctor and Dentist along with your primary insurance ID card (if applicable) whenever you seek medical or dental services for a school related injury.

- Please remember that this plan is **EXCESS** to all other valid coverage. You **MUST** file a claim with your primary insurance carrier first, even if you have a large deductible.

- Students must be treated by a licensed medical or dental provider **within 30 days** from the date of the covered injury**.**

ISDA Illinois School District Agency

ISDA STUDENT ACCIDENT CLAIMS ADMINISTRATOR

2023 - 2024 STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to the 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, and**
3. **Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**

Items #1, #2, and #3 must be submitted to the ISDA Claims Administrator if the Parent or Guardian has other insurance

INSTRUCTIONS

PLEASE RETAIN A COPY FOR YOUR FILES

1. **The Insured's School must complete the application.**
2. **In case of dental injury, the treating dentist must complete the Student Accident Dental Services Form (below).**

NOTICE OF INJURY FROM SCHOOL (Please PRINT)

Name of School and School District _____

Address of the School District (including city, state, and zip code) _____

Name of School Official Reporting Injury _____ School Contact Phone _____

Name of Student _____ Grade of Student _____

Name of Person supervising activity _____ Name of additional witness if any _____

Date of Injury_____Time_____AM/PM

The injury occurred while the student was participating in: **(please CHECK ANY THAT APPLIES)**

INTERSCHOLASTIC SPORTS Football _____ **Game** _____ **Practice**_____ **Name of Sport** _____

ACTIVITY Travel to/from School _____ **Recess** _____ **Physical Education** _____ **Classroom** _____ **School Grounds** _____ **Other** _____

Please specify Other Activity _____

Part of the body injured _____ Right/Left side _____

Describe how injury happened (**Please BE SPECIFIC**):

_____

_____

Name of Parent or Guardian_____ Parent or Guardian Contact Phone_____

Home Address (including city, state, and zip code) _____

Signature of School Official _____ Title _____ Date _____

NOTICE: Anyone who knowingly misrepresents or falsifies material information requested in this Claim Form may invalidate coverage upon such finding.

ISDA Illinois School District Agency

ISDA STUDENT ACCIDENT CLAIMS ADMINISTRATOR

STUDENT ACCIDENT DENTAL SERVICES FORM

TO BE FILLED OUT BY THE TREATING DENTIST

Date of Injury_____ If a Prosthesis is required, is this an initial placement?_____

Was the tooth/teeth sound prior to the current treatment? YES/NO _____

NAME OF DENTAL INSURANCE PLAN _____

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

_____ _____

Print Dentist's Name Dentist's Signature

_____

Street Address

_____

City State Zip

_____

Date

FEDERAL TAX ID NUMBER (REQUIRED FOR PROCESSING)