Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082
1-800-328-2739

USA H&W Network
Provider Selection
800-USA-3860

Be sure to use the services of a USA MCO provider to receive discounts for services provided by physicians and facilities participating in the USA MCO Network.

This plan is supplemental to all other insurance coverage. You must file a claim with your other insurance first.

PROOF OF CLAIM: *When Injury results in treatment by a Physician, complete this form and submit to Student Assurance Services, Inc. within 90 days from date of injury.*

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
   School Address _____ (City) (State) (Zip)
2. Name of Insured _____ Grade _____
3. Date of Injury _____ ☐ AM ☐ PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:

1. INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Practice — What sport/activity?
☐ Game/Event
☐ Travel _____

2. NON-INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Travel to/from school ☐ Non-school activity
☐ In classroom ☐ Other – Activity?
☐ Physical Education _____
☐ On school grounds

6. Part of the body injured _____ ☐ R side ☐ L side
7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) (Date)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
See Attached Claims Filing Information

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Birthdate _____
   Students Social Security # _____
   Parents Name _____ Relationship to Insured _____
   Mailing Address _____
   (Street, Route, or Box) (City) (State) (Zip)
2. Home phone number _____
3. Father's Occupation _____ Employer _____
   Mother's Occupation _____ Employer _____
4. List your family or group coverage, please.
   Name of Insurance Company _____ ☐ Group ☐ Individual ☐ Policy No. _____
   Address _____
   (Street) (City) (State) (Zip)

I hereby 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 STUDENT ASSURANCE SERVICES, INC. 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 expires one year from the date signed. **For electronic filing** - By entering my name below I am indicating my intent to electronically sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ _____ _____
(Date) (Print Name of Student/Patient) (Signature of Parent or Guardian)

ATTENTION PARENTS

*******PARENTS "YOU'RE RESPONSIBLE"*******

Dear Parents,

Below are steps for completing the Claim Form. Should you have any questions, contact the School Trainer/Adminstrator or call the number listed on the claim form. The school "**IS NOT"** responsible for your medical payment or bills for your child. All medical charges are **"YOUR RESPONSIBILITY,"** if your child is injured during **ANY** Athletic (or UIL Activity in Texas) or during any school sponsored and supervised activity.

HOWEVER, the school may have purchased a supplemental policy to cover any charges in excess of your own insurance policy. If you have **NO OTHER INSURANCE** for your child, this policy will then pay first or primary. This is a limited benefit policy and any charges above policy benefit limits are **YOUR RESPONSIBILITY.** This policy was purchased by the district based on funds available. Please be aware that this is a limited benefit policy and by **NO MEANS** was it intended to cover all medical bills for your child. **Your child's treatments and medical charges are your responsibility.**

Please contact the school trainer or administrator before seeking medical treatment or services.

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one claim form for each accident needs to be submitted.

2. The claim form and benefit summary are available at our website: www.sas-mn.com. However, this is not a guarantee of benefits but only an explanation that is subject to all applicable terms, conditions, limitations and exclusions of the plan.

3. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. If the accident is not school related, parent or guardian **may** complete Part A. **This Claim Form must be presented to the physician or facility in order to obtain the USA MCO Provider Discount. Do not leave the claim form with the provider or facility. Complete and submit directly to the Claim's Office at the address indicated below.**

4. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **These itemized bills often called UB04 or CMS 1500 provide the Address, Procedure Code, Diagnosis Code, and the Provider's Tax ID Number.**

5. Submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send our claim form, copies of itemized bills and your other insurance E.O.B.'s to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
1-800-328-2739

TO FILE A CLAIM FORM ON-LINE

Please complete the form fully and follow all steps explained above. When you are satisfied that the claim form is ready to be submitted to SAS, make a copy of the completed claim form to present to the physician or facility as explained above, then either:

a. Mail the claim form with any necessary supporting information, to Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082. Please keep a copy of the claim form your records; OR

b. Click on "Submit Form" in the upper right hand corner of the claim form to electronically send the claim form to SAS. If you have any additional or supporting information mail it to Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082.

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.

PREFERRED PROVIDER DISCOUNT PROGRAM

Student Assurance Services, Inc. has contracted for discounts for services received from physicians and facilities participating in the USA Manged Care Organization Network. Please note that benefits are payable as described whether you use a participating provider or not. However, it is to your advantage to use a participating provider since your costs will be reduced. A listing of participating physicians and facilities are available at the USA MCO Network website **www.usamco.com**.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.