

THIS STUDENT ACCIDENT COVERAGE IS SECONDARY TO ANY INSURANCE COVERAGE INCLUDING MEDICAID, FAMIS OR PRIVATE HEALTH INSURANCE

Please submit claim to those carriers first

STUDENT ACCIDENT CLAIM FORM	
HOW TO FILE YOUR CLAIM	
1. COMPLETE THIS FORM WITHIN 90 DAYS 2. ATTACH ITEMIZED BILLS 3. RETURN TO SCHOOL	
VACo Risk Management Programs 308 Market St., SE Suites 1 & 2 Roanoke, VA 24011 Fax 540-345-5330 or 877-212-8599	



Please Print

PART 1: SCHOOL INFORMATION	
School System:	_____
School Name:	_____
School Address:	_____
Student's Name:	_____
Male or Female (circle one)	Date of Birth: _____
Date of Injury: _____	Time of Injury: _____
Grade Level: _____	Injury Sustained: _____
Description of Accident?	_____
If Athletics, please indicate the sport: _____	
At the time of injury, was the student involved in an activity under the jurisdiction of the School System? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Under whose supervision?	Phone # _____

Signature: _____ Title: _____ Date: _____
 Printed Name: _____ Phone #: _____

PART 2: STUDENT INFORMATION	
Provide both <i>student</i> and <i>parent</i> information	
<i>Student Information</i>	
Student SSN:	Phone # _____
Student Address:	_____
<i>Parent Information</i>	
Father's Name:	Phone# _____
Father's Employer:	_____
Employer's Address:	_____
Mother's Name:	Phone# _____
Mother's Employer:	_____
Employer's Address:	_____
Please list ALL insurance policies: <input type="checkbox"/> Check if No Insurance	
Name of insurer:	_____
Address: _____	<input type="checkbox"/> Group Policy No. _____
Phone #: _____	<input type="checkbox"/> Individual Policy No. _____

Accident insurance coverage is available to cover students for accidental injury occurring while the policy is in force. VACoRMP is the administrator of this coverage.

Benefits are provided on a **SECONDARY** excess basis for covered expenses incurred within a certain time period after the date of the accident.

Benefits are payable to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including, Medicaid, Medicare, and FAMIS.

This claim form must be submitted by the school system to VACoRMP prior to any bills being reviewed or processed.

You must submit your claim to your insurance company first. When you receive your Explanation of benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy contract.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise our benefits may be reduced, where applicable, as stated in the policy provisions.

CLAIM INSTRUCTIONS

In case of accident, notify the school immediately.

1. Treatment must commence within 90 days from the date of the injury.
2. Complete claim form within 90 days from the date of injury. Return this form to the school.
3. If your child is insured under Medicaid, please indicate this.
4. Please attach itemized bills to the claim form. An itemized bill includes treatment rendered, the dates of treatment, physicians or hospital's name, address and tax identification number and diagnosis code. Statements are **not** acceptable without itemized information.
5. If you have any other insurance, your insurance company will send you an Explanation of Benefits (EOB) which shows what they paid or denied. Please attach a copy of the EOB for each itemized bill submitted to for.
6. Benefits are paid to the providers of service unless we receive paid receipts.

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employee having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to VACo Risk Management Programs (VACoRMP) or its legal representative, any and all such information. I UNDERSTAND the information obtained by the Authorized will be used by VACoRMP to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by VACoRMP to any person or organization EXCEPT as necessary in connection with the processing of this application, claim or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to VACoRMP. I certify that the information given by me in support of this claim is true and correct.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS) UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

AFFIDAVIT: I verify that the statement in Part 2 about 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 and state 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 VACo RMP to the extent for which VACoRMP would not have been liable.

Student, Parent or Authorized Representative's Signature: _____ Date _____
If Authorized Representative, Relationship to Student or Legal Designation: _____

