

**PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM**

**ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED**

**NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. The maximum benefit for physician's outpatient treatment in connection with physical therapy and/or spinal manipulation is \$1,000 per non-surgical injury for coverage purchased by the school. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.**

**Claim Guidelines: The following claim guidelines must be followed.**

◆ Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

◆ If you have other insurance, submit your claim to your other insurer. Non-compliance with your primary health HMO/PPO plan will reduce this plans benefits by 50%. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

◆ If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

◆ Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

◆ If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

◆ Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

**Common Causes For Delays In Processing Claims**

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

**KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**

PLEASE PRINT OR TYPE

**HEALTH INSURANCE CLAIM FORM**

1. PATIENT INFORMATION

2. PATIENT AND INSURED INFORMATION

3. PHYSICIAN OR SUPPLIER INFORMATION

4. SERVICE INFORMATION

5. BILLING INFORMATION

6. OTHER INFORMATION

7. SIGNATURES

8. REMARKS

9. OTHER INFORMATION

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PLEASE PRINT OR TYPE

**UB-04**

1. PATIENT INFORMATION

2. PATIENT AND INSURED INFORMATION

3. PHYSICIAN OR SUPPLIER INFORMATION

4. SERVICE INFORMATION

5. BILLING INFORMATION

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**SAMPLE EOB (EXPLANATION OF BENEFITS)**

**UnitedHealthcare**  
A UnitedHealth Group Company

UNITEDHEALTHCARE SERVICE LLC  
GREENSBORO SERVICE CENTER  
P O BOX 740800  
ATLANTA, GA 30374-0800  
PHONE: 1-800-838-8010  
VISIT WWW.MYUHC.COM FOR SELF SERVICE

PAGE: 1 OF 1  
DATE: 04/29/10  
SSN/ID #:   
EMPLOYEE:   
CONTRACT:   
BENEFIT PLAN: PFIZER INC

**EXPLANATION OF BENEFITS**

1	2	3	4	5	6	7	8		
PATIENT/RELAT CLASS NUMBER	PROVIDER/SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061912101	MEDICAL SERVICES	03/19/10	379.00	287.83	81.17		80%	64.94-	4C
		TOTAL	379.00	297.83	81.17			44.54-	
								20.30	

(\*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"  
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

**BENEFIT PLAN PAYMENT SUMMARY INFORMATION**

\$20.30		
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**SCHEDULED 2010 TO DATE**

	DEDUCTIBLE	OUT OF POCKET
FAMILY	\$1000.00	\$1328.77
SP	3500.00	\$1291.48

**PLAN YEAR 2010**

	FAMILY	FAMILY	INDIV	INDIV
2010	\$1000.00	\$4000.00	\$500.00	\$4000.00



STUDENT ACCIDENT INSURANCE CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

- 1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com

IMPORTANT NOTICE:
Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: The accident policy benefits are limited and may not provide 100% coverage.

< IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED >

PART 1-A - TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District Name Collective Liability Insurance Cooperative Policy Number 13-3799-17

District Name Phone No. ( )

Address Email

Type of Activity/Sport

If Athletics, designate P.E. Class Intramural Interscholastic Game Jr. Varsity Varsity
Youth Adult Practice Other

Name of injured person/student

Date of Accident Accident Time

Date of First Treatment Has treatment been completed? Yes No

Where and how did accident occur? (Please be specific)

Part of body Injured Right or Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? Yes No

Under whose supervision? Was he/she a witness? Yes No

Authorized Signature Title Date
(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B - TO BE COMPLETED IN FULL BY CLAIMANT - OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name Preferred/Nickname:

Date of Birth Age Grade Level Male Female

Address of Injured Person or Parents/Guardian

Phone No. ( ) Email Address

If Injured party is over age 18: Employer Name and Address

Phone No. ( ) Self Employed Unemployed

Father/Guardian Name

Employer Name and Address Phone No. ( )

Self Employed Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name \_\_\_\_\_

Employer Name and Address \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Self Employed  Unemployed

Is claimant covered under any other medical and or dental insurance policy?  Yes  No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid?  Yes  No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	Address	Policy #

Are benefits due for this claim under these other insurance coverages?  Yes  No (See IMPORTANT NOTICE at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree?  Yes  No If yes, please give name, address and phone number of responsible party \_\_\_\_\_

**AFFIDAVIT:** I verify that the above statement on 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 laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

**Signature:** Injured Person, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
*SIGNATURE IS REQUIRED*

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

**Signature:** Injured Person, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_