



# STUDENT INSURANCE CLAIM FORM

Mail Completed Form To:

educational & institutional insurance administrators, inc.

Summit America Insurance Services  
7400 College Blvd., Suite 120  
Overland Park, KS 66210  
For questions call: 1 (800) 926-3441

Policy #:

## PART 1 - MUST BE COMPLETED & SIGNED BY STUDENT

SCHOOL NAME, CITY, STATE & ZIP:

INSURED STUDENT'S NAME:

STUDENT ID #: \_\_\_\_\_

DATE OF BIRTH (MO/DAY/YEAR): \_\_\_\_/\_\_\_\_/\_\_\_\_

FEMALE  GRADUATE  SINGLE  DOMESTIC   
MALE  UNDERGRADUATE  MARRIED  INTERNATIONAL

Student School Year Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Please check here if this address has changed since August 1st.

Home /Permanent Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Please check here if this address has changed since August 1st.

If claim is for a dependent, give dependents full name:

**M  
U  
S  
T  
B  
E  
C  
O  
M  
P  
L  
E  
T  
E  
D**

**B  
L  
A  
N  
K  
S  
A  
R  
E  
N  
O  
T  
A  
C  
C  
E  
P  
T  
A  
B  
L  
E**

If the student is insured, all charges must be filed with the other insurance carrier first and copies of the Explanation of Benefits (EOBs) will be required for all charges submitted.

If the student is not insured, a letter denoting lack of coverage or verification by telephone from the employer or insurance company is required. N/A or blanks are not acceptable, please submit complete information.

Head of Household: \_\_\_\_\_ Other Parent/Spouse: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_

Insurance Co. ID#: \_\_\_\_\_ Insurance Co. ID #: \_\_\_\_\_

Is Student Insured: Yes  No  Is Student Insured: Yes  No

ACCIDENT  INTERCOLLEGIATE SPORTS: NO

1. This claim is for a(n):

2. Exact *Date/Onset* of Accident or Sickness:

3. *Reason* for seeking medical treatment :

4. If an Accident, describe how it occurred: \_\_\_\_\_ Body Part: \_\_\_\_\_

5. First date of medical treatment:  
(Include Medical provider's name & phone #)

6. Have you *previously* been troubled by this Condition/Injury? NO  YES  When: \_\_\_\_/\_\_\_\_/\_\_\_\_ Prior treating physician (name & phone number): \_\_\_\_\_

7. Were you seen and/or referred by the Student Health Service? NO  YES  When: \_\_\_\_/\_\_\_\_/200\_\_ Authorized by: \_\_\_\_\_



# CLAIM FILING PROCEDURES

## IMPORTANT

- ◆ Initial medical treatment must take place within **90** days from the date of Accident or Sickness.
- ◆ A claim must be filed within **180** days from the first date of treatment.
- ◆ The Insured Student must be under the care of a Doctor when the eligible Expenses are incurred.

Please read the following instructions carefully. If you are unsure about any one of the following requirements, please contact your Student Insurance Coordinator or Summit America Insurance Services at 1(800) 926-3441.

1. An Accident must be reported to the Student Insurance Coordinator within 24 hours following the Accident. Accidents incurred during supervised practice or play should be reported to the Athletic Trainer or Athletic Department Official immediately following the injury.
2. If the student is insured by an HMO, PPO or similar arrangement, they should be contacted for proper instruction or authorization on covered health care. HMO & PPO Plans must be utilized. If you do not use the facilities or services of the HMO, PPO or similar arrangement, medical benefits may be reduced by 50%.
3. The coverage afforded by the Student Accident & Sickness Plan may provide benefits in **EXCESS** of any other coverage the student may have. If so, all eligible charges submitted must be accompanied by an Explanation of Benefits (EOB) from the primary insurance carrier(s). The Insurance Section in Part 1 of this Claim Form must include insurance information for BOTH parents if the student is under 23 years of age or a spouse if they are married. Blank lines or N/A are not acceptable.
4. Incomplete Claim Forms will result in a processing delay. Allow up to 4 weeks for processing after all information is received.
5. Please ensure that all bills are itemized, listing the patient's name, date of service, diagnostic code, service code and the provider's tax identification number. (HCFA 1500 and UB92 forms are preferable)
6. File only one Claim Form per loss (Accident or Sickness). Once the initial Claim Form has been filed, additional information submitted should be identified with the school's name, the student's name, ID# and the initial date of loss.

(Detach and Save)

---

### INSTITUTION'S AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

Although an authorization is not required for payment, treatment and operations of a medical claim, our institution would like authorization to disclose information necessary in determining the eligibility of your student medical claim. Information will only be disclosed to the extent that it is necessary by the parties listed below to determine eligibility and medical benefits.

Institution Name: \_\_\_\_\_ City & State: \_\_\_\_\_

I authorize the above named institution and its Insurance Coordinators to use or disclose my medical or benefit records, including any individually identifiable health information contained in these records with Fairmont Specialty, Summit America Insurance Services, E.I.I.A., Inc. and other medical providers for the purpose of determining the eligibility and benefits of my student medical claim.

I understand these records may contain information created by other persons, entities, health care providers, the athletic department and the student health center. The records may include diagnosis and treatment information, including information pertaining to congenital conditions, chronic diseases, behavioral health conditions, alcohol or substance abuse and communicable diseases such as HIV/AIDS. I understand that once health information about me has been disclosed to a third party, the health information may no longer be protected by federal privacy laws.

I understand that I may revoke this authorization at any time by notifying the above named institution in writing.

This authorization is valid for 24 months (2 years) from the date of signature or until such time as my written revocation is received by the above named institution.

Print Insured Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Submit claims to:  
**SUMMIT AMERICA INSURANCE SERVICES, LC**  
7400 College Blvd., Suite 120  
Overland Park, KS 66210

Phone: 1 (800) 926-3441  
Fax: (913) 327-7520  
E-mail: [EIIA@summitamerica-ins.com](mailto:EIIA@summitamerica-ins.com)

