

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

Please submit claim to those carriers first

HOW TO FILE A CLAIM:

1. COMPLETE THIS FORM WITHIN 90 DAYS
2. ATTACH ITEMIZED BILLS
3. RETURN TO SCHOOL

VACoRP
308 Market St., SE Suites 1 & 2
Roanoke, VA 24011
Fax 540-345-5330 or 877-212-8599



VACoRP

Please Print

PART 1: SCHOOL INFORMATION

School System: Washington County
School Name: _____
School Address: _____
Student's Name: _____ DOB: _____
Male or Female (circle one) 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? Yes No
Under whose supervision? _____ Phone #: _____

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

PART 2: STUDENT/PARENT INFORMATION

Student SSN: _____ Phone #: _____
Student Address: _____
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: Check if No Insurance
Name of insurer: _____
Address: _____ Group Policy No. _____
Phone #: _____ Individual Policy No. _____

Accident insurance coverage is available to cover students for accidental injury occurring while the contract is in force.

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

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

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

If the 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 contract 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, physician 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 EOB which shows what they paid or denied. Please attach a copy of the EOB for each itemized bill submitted.
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 child(ren) now or in the past, to give to VACoRP and/or VACo Risk Management Programs (VACoRMP) or a legal representative of either one, any and all such information.

I UNDERSTAND the information obtained by the Authorized will be used by VACoRP and/or VACoRMP to determine eligibility for benefits under any existing Student Accident coverage. Any information obtained will not be released by VACoRP and/or 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 VACoRP or 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 that I will reimburse VACoRP and/or VACoRMP to the extent of the other insurance whether I collected payment on the other insurance, or not.

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



VACoRP