



SISC

Self-Insured Schools of California
Schools Helping Schools

TO: Parent(s)/Guardian

SUBJECT: Student Accident Coverage Reporting and Claim Filing Procedure

Student Accident Coverage is SECONDARY to any other insurance which provides medical benefits to your child. SISC is primary to Medi-Cal and Tricare. A claim must be filed with your primary insurance carrier (e.g., Blue Cross, Blue Shield) at the same time you file a Student Accident Coverage claim. ***If you subscribe to an HMO (Health Maintenance Organization), you must use it.***

If you have primary insurance, a copy of the "Explanation of Benefits" (how your insurance has processed the claim) from your insurance carrier is needed to process the Student Accident Claim.

Note: Student Accident Coverage has a maximum benefit of \$2,500.00 for services rendered as a result of bodily injury. Treatment must begin within 30 days of the injury and benefits are only payable for services rendered within one year of the date of the injury. Physical therapy and chiropractic services are subject to additional limitations. The completed SISC claim form must be submitted to SISC within one year (52 weeks) of the date of injury.

ALL SECTIONS NEED TO BE COMPLETED OR YOUR CLAIM WILL BE RETURNED.

1. Report accidental injury to appropriate school official immediately.
2. Have designated school employee complete and sign the school's section of the claim form.
3. The claim form **must be filled out completely**—all areas need the specific information which is requested and the parents/guardians need to sign all the appropriate spaces.
4. Give a copy of the completed claim form to all providers to be billed directly to SISC.

OR

5. Send the completed claim form along with itemized bills and Explanations of Benefits (EOBs) if applicable to:
SISC - Student Accident Coverage - P.O. Box 1847 - Bakersfield, CA 93303-1847
You can also fax the necessary documents to: **Fax No.: (661) 636-4418** or
Email them to: sisc_pl@siscschools.org

For your personal records, please keep a copy of all submitted paperwork.

Please direct any questions you may have regarding Student Accident Coverage to (661) 636-4710.

RK
Enc.

P.O. Box 1847, Bakersfield, CA 93303-1847

2000 K St. Larry E. Reider Education Center, Bakersfield, CA 93301

ph: 661.636.4710 fax: 661.636.4418 siscschools.org

A Joint Powers Authority administered by the Kern County Superintendent of Schools Office, Mary C. Barlow, Superintendent

PARA: Los Padres/Tutores

ASUNTO: Procedimiento para reportar accidentes escolares y presentar un reclamo.

La cobertura para Accidentes Escolares es SECUNDARIA a cualquier tipo de seguro médico privado que su hijo/a tenga. La cobertura SISC es solamente primaria a Medi-Cal y Tricare. El reclamo se debe presentar a su seguro médico primario (por ejemplo, Blue Cross, Blue Shield), al tiempo que reporta el reclamo de Cobertura para accidentes escolares. ***Si usted pertenece a una Organización para Mantenimiento de la Salud (HMO), usted debe utilizar esa cobertura apropiadamente.***

Si usted tiene seguro médico primario, se necesita la copia del reporte de sus beneficios de salud de su seguro médico (reporte que explica como su seguro médico ha procesado su reclamo), para poder tramitar el reclamo de Cobertura Para Accidentes Escolares.

Nota: La cobertura para Accidentes Escolares tiene una indemnización máxima de \$2,500.00 por servicios médicos prestados como resultado de una lesión corporal. La primera consulta médica debe realizarse en el transcurso de los primeros 30 días después del accidente. Solo se indemnizará por servicios médicos prestados dentro de un año a partir de la fecha del accidente. Los servicios de fisioterapia y tratamiento quiropráctico están sujetos a restricciones adicionales. El formulario de reclamación completo se debe enviar SISC dentro de un año (52 semanas) después de la fecha del accidente.

DEBEN LLENAR LA FORMA DE RECLAMO EN SU TOTALIDAD O LA FORMA SERA DEVUELTA.

1. Reporte inmediatamente lesiones accidentales al representante de la escuela que corresponda.
2. Pida que el representante designado por la escuela llene y firme la parte correspondiente a la escuela.
3. El Formulario de reclamación **debe llenarse completamente** -- todas las secciones deben tener la información específica requerida, y los padres o tutores del niño deben firmar en los espacios correspondientes.
4. Entregue una copia del formulario de reclamo a los proveedores de servicios médicos para que manden los cobros directamente a SISC.
5. Envíe el formulario de reclamo completo ^ó junto con las facturas detalladas y la explicación de beneficios (si corresponde) a:
SISC- Student Accident Coverage, P.O. Box 1847, Bakersfield, CA 93303-1847.
También puede enviar los documentos necesarios por fax o correo electrónico:
Fax No.:(661) 636-4418 Email: sisc_pl@siscschools.org

Antes de enviar los documentos, es recomendable que haga copias para sus archivos personales.

Cualquier pregunta concerniente a la Cobertura Para Accidentes Escolares debe dirigirse a esta oficina llamando al número de teléfono (661) 636-4710.

RK:el
Adjunto

Claim # _____

STUDENT ACCIDENT CLAIM FORM

(Grades Preschool through 12)

Mail To: SISC Student Accident Claims,
P.O. Box 1847
Bakersfield, CA 93303-1847
Ph. (661) 636-4710 Fax: (661) 636-4418 Email: sisc_pl@siscschools.org

Supplemental Coverage

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (Check Yes or No)

- A. Non-school related activity? Yes No
B. Supervised school activity? Yes No
C. Field trip activity? Yes No
D. Supervised off-campus activity? Yes No
E. Sponsored and supervised travel? Yes No
F. Supervised athletic practice/competition? Yes No

Sport _____

Name and Title of Supervising School Authority:

Name _____

Title _____

Signature _____

School District _____

School Name _____

STUDENT'S FULL NAME

MAILING ADDRESS

CITY

ZIP

DATE OF BIRTH

SOCIAL SECURITY #

GRADE

SEX

TELEPHONE

M

F

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time: _____ a.m. _____ p.m.

3. When did the student first consult a physician for this condition? Date: _____

Completed by _____ Date _____

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S)

SISC Accident Coverage is secondary to your private health insurance.

1. Father/Guardian Name _____ EMPLOYED: Yes _____ No _____

Employer _____ Employer Telephone () _____

Individual and/or

Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes _____ No _____

I authorize the release of any information necessary to process this claim.

I authorize payment of medical benefits to physician or supplier of service.

Signature _____ Date _____

Signature _____ Date _____

2. Mother/Guardian Name _____ EMPLOYED: Yes _____ No _____

Employer _____ Employer Telephone () _____

Individual and/or

Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes _____ No _____

I authorize the release of any information necessary to process this claim.

I authorize payment of medical benefits to physician or supplier of service.

Signature _____ Date _____

Signature _____ Date _____

IMPORTANT: All hospital and doctor bills must be itemized.

NOTICE TO PROVIDERS: A copy of this claim form needs to be attached to your bill.

Reclamo # _____

FORMULARIO DE RECLAMACIÓN ACCIDENTE ESCOLAR

(Grados Preescolar - 12)

Enviar a: SISC Student Accident Claims

P.O. Box 1847

Bakersfield, CA 93303-1847

Ph (661) 636-4710 Fax (661) 636-4418

Email: sisc_pl@siscschools.org

Cobertura Suplementaria

TO BE COMPLETED BY SCHOOL OFFICIAL – LO DEBE LLENAR UN FUNCIONARIO ESCOLAR

Did the accident occur **during** (Check Yes or No)

A. Non-school related activity?

Yes No

B. Supervised school activity?

Yes No

C. Field trip activity?

Yes No

D. Supervised off-campus activity?

Yes No

E. Sponsored and supervised travel?

Yes No

F. Supervised athletic practice/competition?

Yes No

Name and Title of Supervising School Authority:

Name _____

Title _____

Signature _____

School District _____

School Name _____

Sport _____

STUDENT'S FULL NAME

MAILING ADDRESS

CITY

ZIP

DATE OF BIRTH

SOCIAL SECURITY #

GRADE

SEX

TELEPHONE

M

F

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time: _____ a.m. _____ p.m.

3. When did the student first consult a physician for this condition? Date: _____

Completed by _____ Date _____

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S) – LO DE BE LLENAR PADRE / MADRE O TUTOR LEGAL

La cobertura SISC para accidentes escolares es suplemental a su seguro médico privado.

1. Nombre del padre/tutor _____ TRABAJA: Sí _____ No _____

Empleador _____ Número de teléfono de la compañía _____

Compañía de seguro
de plan Individual y/o de grupo _____ # de Póliza _____

de Seguro Social _____ ¿El menor tiene cobertura médica mediante este plan? Sí _____ No _____

Autorizo que se divulgue cualquier información necesaria para
procesar este reclamo.

Autorizo el pago de beneficios médicos para el médico o el
suministrador de servicio.

Firma _____ Fecha _____ Firma _____ Fecha _____

2. Nombre del madre/tutor _____ TRABAJA: Sí _____ No _____

Empleador _____ Número de teléfono de la compañía _____

Compañía de seguro
de plan Individual y/o de grupo _____ # de Póliza _____

de Seguro Social _____ ¿El menor tiene cobertura médica mediante este plan? Sí _____ No _____

Autorizo que se divulgue cualquier información necesaria para
procesar este reclamo.

Autorizo el pago de beneficios médicos para el médico o el
suministrador de servicio.

Firma _____ Fecha _____ Firma _____ Fecha _____

IMPORTANTE: Todas las facturas del hospital y el médico deben ser detalladas.

AVISO A LOS PROVEEDORES: Envíe una copia de este formulario al enviar las facturas médicas.