SISC
Self-Insured Schools of California
Schools Helping Schools

Tackle Football

TO: Parent(s)/Guardian(s)

SUBJECT: SISC ***Tackle Football*** Coverage

SISC Tackle Football Coverage is ***secondary*** to any other insurance which provides medical benefits to your child. 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 Tackle Football Claim. ***If you subscribe to an HMO (Health Maintenance Organization), we recommend you use it to get maximum benefits.***

SISC is ***primary*** to Medi-Cal and Tricare. SISC becomes primary if you have no other insurance coverage.

Claims submitted to SISC Tackle Football Coverage are paid according to a schedule of benefits. A schedule of benefits is included on the back of this claim form and in the application brochure. **Please read it carefully.** In some cases, not all charges will be paid, leaving a balance that is your responsibility. When payments are made, you will receive an Explanation of Benefits (TF-EOB) showing what was paid and any remaining balance due.

The completed Tackle Football form must be submitted to SISC within one year of the date of injury. Benefits are only payable for services rendered within one year of the date of the injury. Treatment must begin within 30 days of the injury.

SUBMITTING A CLAIM:

1. Report the injury to the appropriate school official immediately.
2. Obtain a Tackle Football claim form and have the appropriate school official complete and sign the school's section of the form.
3. Complete **all** remaining sections of the form, including signatures.
4. Give a copy of the completed claim form to all providers involved with your child's treatment so they can bill SISC directly.

   OR

5. Send the completed claim form along with itemized bills and Explanation of Benefits (EOB's) 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 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 Tackle Football Coverage to (661) 636-4736

RK:
Enc.

PO Box 1847, Bakersfieldd, CA 93303-1847
2000 K St. Larry E. Reider Education Center, Bakersfield, CA 93301
ph: 661.636.4710 fx:661.636.4418 siscschools.org

File # _____

SISC TACKLE FOOTBALL CLAIM FORM

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

TO BE COMPLETED BY SCHOOL OFFICIAL

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

A. School sponsored tackle football practice?
❑ Yes ❑ No

B. School sponsored tackle football competition?
❑ Yes ❑ No

C. School sponsored and supervised tackle football transportation?
❑ Yes ❑ No

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.

Signature_____ Date_____

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

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.

Signature_____ Date_____

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

Signature_____ Date_____

IMPORTANT – PARENT'S RESPONSIBILITY: Injuries MUST be treated by a properly authorized Physician or Dentist. All hospital and doctor bills must be itemized.

SUMMARY OF BENEFITS

Surgical Allowances.....100% to $1,000 .00

X-RAYS in or out of hospital including reading or interpretation thereof but excluding dental X-rays, not to exceed the amount specified below as the result of any one accident.....$200.00
Diagnostic Imaging (MRI/CAT scan) Aggregate charges $750.00

Anesthesia Allowance.....up to $250.00

Assistant Surgeon Paid .....up to $250.00

Physician's Services:

Initial Call.....$45.00
Initial ER Call $75.00
Subsequent Calls $25.00

Physical therapy/Chiropractic Services ..... 15 visits@ $25.00

Hospital Room and Board, per day, up to.....Semi-Private Rate

Intensive Care, per day, up to.....2 x Semi-Private Rate

Hospital Miscellaneous, Inpatient Expense, up to .....80% to $5,000.00

Emergency Room Care , up to $500.00

Dental, per tooth $500.00

Outpatient Surgery Facilities (room and supplies).....80% to $2,000.00

Orthopedic Appliances prescribed by a Physician..... Usual and customary

Casting Supplies..... Usual and customary

Land Ambulance..... Usual and customary

Outpatient Drugs ..... Usual and customary

Outpatient Lab Benefit.....$75.00

Eye Glass Replacement of broken eye glasses , frames, lenses resulting from a covered accident. This benefit is payable only if an injury which requires medical or surgical treatment results from the same accident. Routine Refractions or Routine Eye Examinations are not covered $100.00