KidGuard CLAIM FORM

CLAIM FORM AND NOTICE OF INJURY TO BE MAILED TO:
KidGuard, P.O. BOX 784268, WINTER GARDEN, FLA. 34778-4268
The underwriting insurance company is Everest Reinsurance, Wilmington, DE..

PARENTS: Policy limitations and exclusions are on the take home summary of insurance brochure. The Policy does not pay 100% of billed expense. It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This is ***'Excess Insurance***'. **Y**ou MUST file a claim with your primary insurance first. A school Official is required to fill out PART B only if the injury is school related. This form cannot be processed unless all questions are answered below and all signatures are in place. It is the duty of the claimant,(Parent/Legal Guardian), to furnish the company with itemized bills, explanation of primary insurance benefits paid, and this form completed. Visit KidGuard.com for information regarding where to seek treatment and claim filing instructions. THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS AFTER DATE OF ACCIDENT. The policy allows for bills to be sent in for up to one year from the date of accident. **PLEASE DO NOT LEAVE THIS FORM WITH YOUR PHYSICIAN OR HOSPITAL.** It is the parent/guardian's responsibility to ask Doctors/ Providers what remaining balances you may be required to pay regarding this claim, if any.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A. Please print your answers.

1. Name of School: County: Grade:

2. Last Name of Student: First Name: Middle Initial:

3. Mailing Address of Parent: City: State: Zip:

4. Home Phone # ( ) - Date of Birth / /

5) **WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW, WHEN AND WHAT OCCURRED, THAT CAUSED THE INJURY. (Use back of this form if more space is needed).** How? What? When? Be specific please.

6. **INJURY DATE:** Month Day Year Time AM ◉ PM ○ Where did the accident happen?

If this is sports related what is the name of the team or camp?

7. Nature of Injury or sickness (indicate part of body injured-such as broken arm, sprained ankle etc…)

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this line blank).
Other insurance includes but is not limited to the following: HMO's, PPO's BC/BS, United, Employer Benefits, ERISA, Medicaid, Welfare or Government Trust accounts, or Tri-care. **It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This policy will not pay for 100% of billed charges.** What is deductible or co-pay (if any)? $

If you have a Medicaid plan please send a copy of your insurance card with this form.

9. Address of claims office of insurance company on line 8.

10. Mother's Name and Employer: Occupation:

Mother's Employer Address: Telephone #

11. Father's Name and Employer: Occupation:

Father's Employer Address: Telephone #

****The above answers are true and correct. I hereby authorize any person or institution to release any information requested by the insurance company or its agent to them, including history and physical, diagnosis or other medical or insurance information. A photo static copy of this authorization shall be considered as effective and valid as the original. **STATE LAW:** "Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree." Please refer to state specific fraudulent statements below.*

12. PARENT/GUARDIAN SIGN HERE: Today's Date: / / Print Name:

PART B - Must be filled out and signed by a School Official for ALL school sports related injuries. Must be filled out for all other school related injuries unless the student purchased the 24 Hour Plan.

1. WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW THE ACCIDENT OCURRED THAT CAUSED THE INJURY. Please be specific. (Use back of this form if more space is needed.)

2. Injury Date: Month Day Year Time AM ○ or PM ○ Part of body injured (include whether right or left)

3. At the time of the injury was the student involved in a school sponsored, funded, scheduled and supervised activity? YES ○ NO ○

Please select or list the interscholastic sport or activity the student was participating in. Circle One.
P.E. Class - Football Game - Football Practice - Soccer - Volleyball - Baseball - Softball - Track - Wrestling - Flag Football - Competitive Cheerleading - Rugby Lacrosse-- Side line Cheerleading - Basketball OTHER LIST

4. Under whose supervision(witness)? What date has the Athlete returned to play if applicable? / /

5. Print Name of School Official School phone Number: - -

6. **Original Signature of School Official** (Only if injury is School Related) Today's Date: / /

Please DO NOT LEAVE THIS FORM with the Doctor or Hospital. Mail to KidGuard immediately upon completion.

PART C: ATTENDING PHYSICIAN OR DENTIST STATEMENT. Itemized bills are required to determine the eligibility of a claim. **If the provider is going to bill us directly you do NOT need to have PART C completed.**

1. Diagnosis and Concurrent conditions. Explain any complications._____

2. Date you first treated the sickness or injury____/____/_____ Dates of subsequent treatment: _____

3. When did the symptoms first appear? Date: _____

4. Were your services necessary solely because of the incident described in part A(front)? YES ◯ NO ◯ Is treatment completed? YES ◯ NO ◯

5. Did any previous injury, sickness or impairment contribute to this injury? YES ◯ NO ◯ If yes, explain details._____

_____

6. Did x-ray show fracture? YES NO If fracture or dislocation, state whether reduced or immobilized and what the procedure was?

_____CPT/CRVS_____

7. Physician's Degree (M.D.,etc.)_____Print name of physician or dentist: _____

8. Federal tax ID# (or Soc. Sec. #) _____**(Benefits cannot be paid to you without this).**

9. Address of physician or dentist. STREET NUMBER_____

CITY_____STATE_____ZIP CODE_____***Signature of physician or dentist***: _____

10. FOR DENTAL CLAIMS ONLY: Indicate which teeth were involved in the accident? _____
11. Describe condition of injured teeth prior to accident: **Circle conditions:**
Filled--- Capped--- Artificial--- chipped--- broken--- crowned- damaged--- abscessed---Otherwise Fitted--- Whole, sound and natural--- Other_____

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

1) You must file your claim with your other (Primary) insurance company first. Other insurance include, but not limited to: HMO's, PPO's BC/BS, United, Employer Benefits, HSA's or Tri-care***. This is secondary coverage*** and may not pay for 100% of medical expenses incurred. When your claim has been processed by your primary insurance; mail a copy of the explanation of benefits (EOB's), the itemized bills to *KidGuard Insurance.* **We cannot accept a balance due statement, itemized bills are required. *Important note*: Please do not leave the claim form with the Hospital or Doctor's Office.** Participants can seek treatment from any licensed provider of service. **It is the participants responsibility to find out what out of pocket expenses they could incur. Please ask your provider of service if they are in your primary network. Visit KidGuard .Com for provider information.**

2) **A completed KidGuard Claim Form must be submitted within *90 days* from the date of the incident**. If the condition is school related or happened at school Part B must be completed. If the condition did not happen at school complete Part A and mail directly to KidGuard for additional information please contact KidGuard Insurance 1-800-432-6915.

3) The plan administrator mailing address is: **KidGuard**

P.O Box 784268
Winter Garden, FL. 34778-4268

Reasons claims are delayed for processing: **1**. Claim Forms Not Completed In Full or Not Submitted. **2**. Balance Due Statements, Balance Forward Statements, or Past Due Statements submitted instead of the correct Medical Itemized Bills (UB-04/92 or HCFA-1500) which are standard forms used by providers of service or Doctors. **3**. Explanation of Benefits from Primary Insurance Carrier not provided with the correct bills.

If we do not receive your reply within 45 days, we will close our file. However, upon receipt of the requested information, we will reopen the file and process your claim in accordance with the policy provisions.

ADDITIONAL
COMMENTS:_____

_____

_____

_____

FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

RESIDENTS OF FLORIDA APPLICANTS: "ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

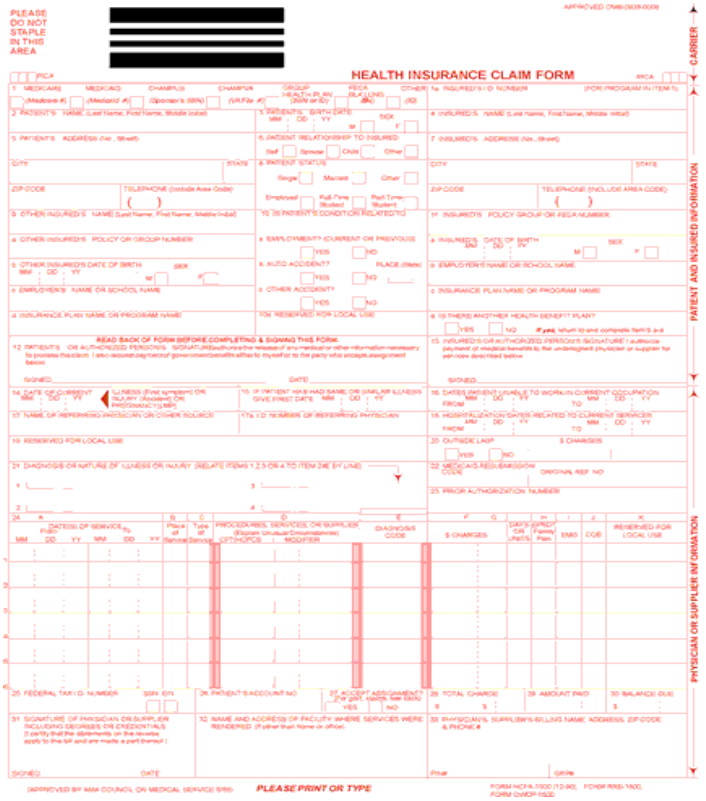
RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY "MATERIALLY" FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME."

RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

SAMPLE HCFA 1500

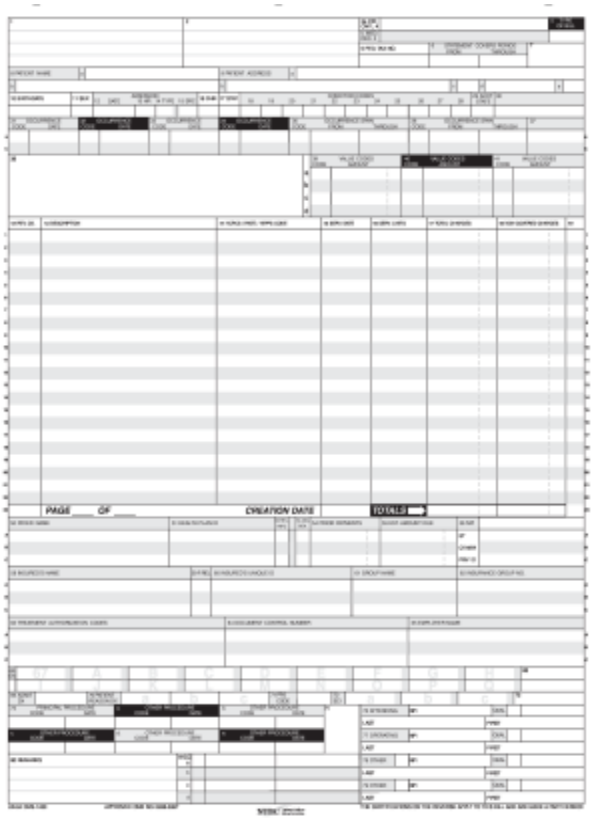


PLEASE DO NOT STAPLE IN THIS AREA

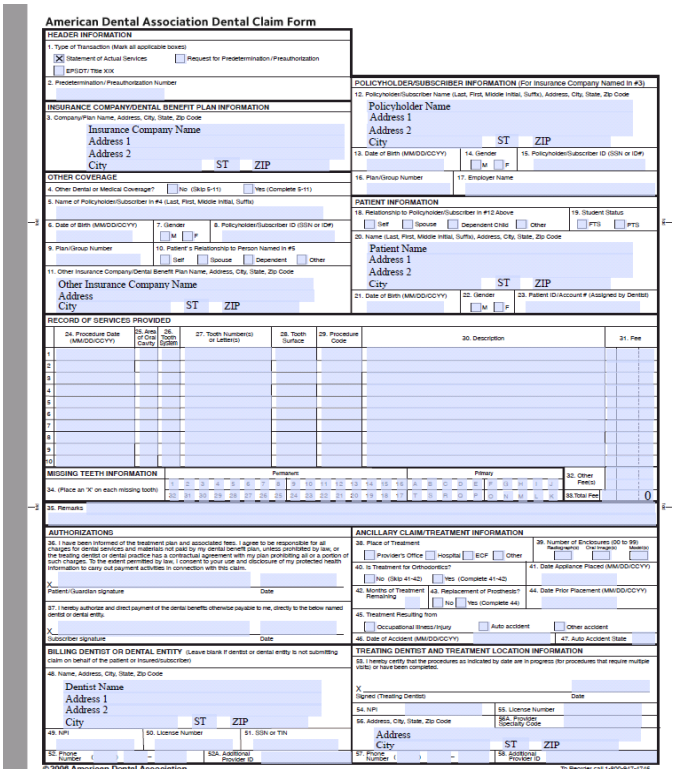
HEALTH INSURANCE CLAIM FORM

PLEASE PRINT OR TYPE

SAMPLE UB-04



SAMPLE ADA DENTAL CLAIM FORM



American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services
Request for Predetermination / Preauthorization
EPSDT/ Title XIX

2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Insurance Company Name
Address 1
Address 2
City ST ZIP

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip to 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender M F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5
Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Policyholder Name
Address 1
Address 2
City ST ZIP

13. Date of Birth (MM/DD/CCYY)

14. Gender M F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
Self Spouse Dependent Child Other

19. Student Status
FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient Name
Address 1
Address 2
City ST ZIP

21. Date of Birth (MM/DD/CCYY)

22. Gender M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH INFORMATION

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

Primary: A B C D E F G H I J K L M N O P Q R S T

32. Other Fee(s)

33. Total Fee 0

34. (Place an 'X' on each missing tooth)

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

38. Name, Address, City, State, Zip Code
Dentist Name
Address 1
Address 2
City ST ZIP

39. NPI

40. License Number

41. SSN or TIN

42. Phone Number ( ) -

43. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

44. Place of Treatment
Provider's Office Hospital ECF Other

45. Number of Enclosures (00 to 99)
Radiographs/Perio Chart Images Models

46. Is Treatment for Orthodontics?
No (Skip 47-52) Yes (Complete 47-52)

47. Date Appliance Placed (MM/DD/CCYY)

48. Months of Treatment Remaining

49. Replacement of Prosthesis?
No Yes (Complete 50)

50. Date Prior Placement (MM/DD/CCYY)

51. Treatment Resulting from
Occupational Illness/Injury Auto accident Other accident

52. Date of Accident (MM/DD/CCYY)

53. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

55. NPI

56. License Number

56A. Provider Specialty Code

57. Address, City, State, Zip Code
Address
City ST ZIP

58. Phone Number ( ) -

58A. Additional Provider ID

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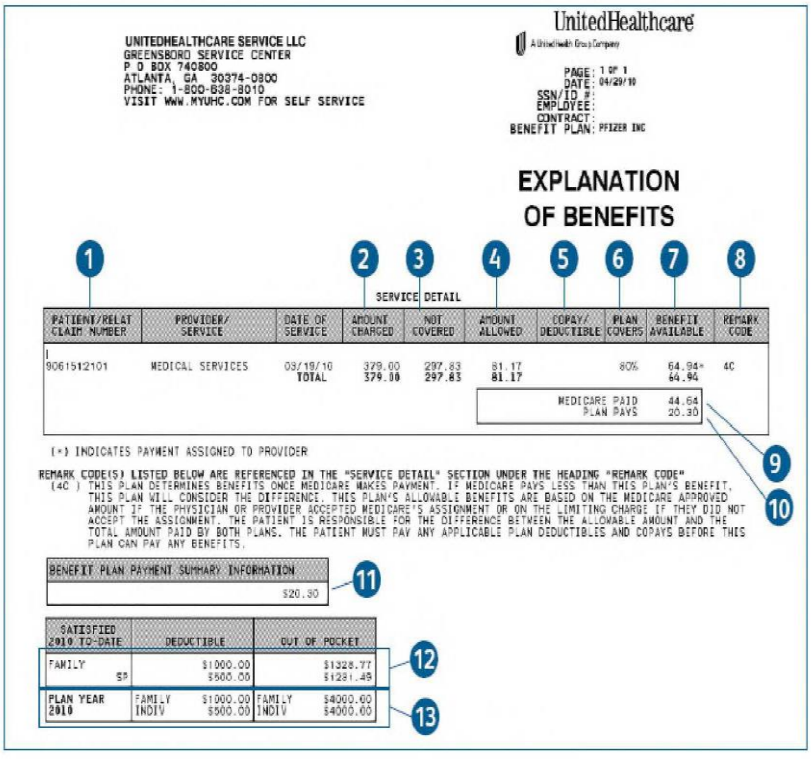
SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

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

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	2 DATE OF SERVICE	3 AMOUNT CHARGED	NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
		TOTAL	379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	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	11
$20.30	

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET	
FAMILY	$1000.00	$1328.77	12
SP	$500.00	$1281.45	
PLAN YEAR 2010 FAMILY	$1000.00	$4000.00	13
PLAN YEAR 2010 INDIV	$500.00	$4000.00	