KidGuard®
A DOXA COMPANY

PARENTS: Submit by email to Claims@KidGuardInsurance.com (mail only if needed).

- This is excess insurance, you must file with your primary insurance first and may have a remaining balance.
- To process your claim, submit this completed form. Include itemized medical bills and your primary insurance Explanation of Benefits (EOB).
- Part B must be completed by a school official for all school-related injuries.
- File within 90 days of the accident (bills accepted up to 1 year); do not leave this form with your provider—you are responsible for submitting it.
- See your brochure for limits/exclusions or visit www.KidGuardInsurance.com; underwritten by Everest Reinsurance Company.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A

1. Name of School: District/County: Grade:
2. Last Name of Student: First Name: Middle Initial:
3. Parent Mailing Address: City: State: Zip:
4. Home Phone ( ) - Student Date of Birth MM/DD/YYYY:

Parent/Guardian Email 1: Parent/Guardian Email 2:

5. **PROVIDE A DETAILED DESCRIPTION OF WHAT OCCURRED THAT CAUSED THE INJURY. How? What? When? Be specific please.**

6. **INJURY DATE** MM/DD/YYYY: Time: AM ○ PM ◉ Where did the accident happen?

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

7. Nature of Injury (indicate body part injured-such as broken arm, sprained ankle etc.) **LEFT** ○ **RIGHT** ◉

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this 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. **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. Insurance Company Claims Website:
10. Mother's Name: Mother's Employer: Occupation:

Mother's Employer Address: Telephone #:

11. Father's Name: Father's Employer Occupation:

Father's Employer Address: Telephone #:

By submitting this form, I certify that the information provided is true and correct. I authorize the release of any medical and insurance information requested by the insurance company or its agent to process this claim.

12. PARENT/GUARDIAN PRINTED NAME **Today's Date** (MM/DD/YYYY)

PART B: MUST BE COMPLETED BY A SCHOOL OFFICIAL for ALL school sports 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.

2. Injury Date MM/DD/YYYY: Time: AM ○ PM ○ Part of body injured (include 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 list the interscholastic sport or activity the student was participating in. Select only one.
P.E. Class; Football Game; Football Practice; Soccer; Volleyball; Baseball; Softball; Track; Wrestling; Flag Football; Competitive Cheerleading; Rugby; Lacrosse; Sideline Cheerleading; Basketball; OTHER

4. Under whose supervision (witness)? Date Athlete returned to play, if applicable? MM/DD/YYYY:
5. Name of School Official Completing this form: School phone number:
6. Today's Date MM/DD/YYYY:

PART C: ATTENDING PHYSICIAN OR DENTIST STATEMENT

Itemized bills are required to determine eligibility of a claim. If the provider is going to bill us directly you do NOT need to complete PART C

1. Diagnosis and Concurrent conditions. Explain any complications.
2. Date you first treated the sickness or injury MM/DD/YYYY: Dates of subsequent treatment MM/DD/YYYY:
3. What date did the symptoms first appear? MM/DD/YYYY:
4. Were your services necessary solely because of the incident described in part A of this form? YES ○ NO ○ Is treatment completed? YES ○ NO ○
5. Did any previous injury, sickness or impairment contribute to this injury? YES ○ NO ○ If yes, explain:
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.) Name of Physician/Dentist:
8. Federal tax ID# (or Soc. Sec. #) **(Benefits cannot be paid to you without the tax identification).**
9. Address of physician or dentist. STREET NUMBER

CITY STATE ZIP

10. FOR DENTAL CLAIMS ONLY: Which teeth were involved in the accident?
11. Describe condition of injured teeth prior to accident: *Filled; Capped; Artificial; Chipped; Broken; Crowned; Damaged; Abscessed; Otherwise Fitted; Whole, sound & 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 includes, but is 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; email a copy of the explanation of benefits (EOB's) and the itemized bills to Claims@KidGuardinsurance.com. **We cannot accept a balance due statement, itemized bills are required. *Important note***: 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. For claim or coverage questions, please visit www.KidGuardinsurance.com for more information or to download a claim form.**

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 email to Claims@KidGuardinsurance.com. For additional information please contact KidGuard Insurance 1-800-432-6915.

3) The plan administrator is: **Claims@KidGuardinsurance.com (for submitting claim forms, EOB's and itemized bills)**
Mailing address: KidGuard Insurance, P.O Box 140926, Orlando, FL 32814

Reasons claims are delayed for processing

- Claim Forms are not Completed In Full or Not Submitted.
- 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.
- 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:

KidGuard is a division of DOXA Programs, LLC, an Indiana limited liability company. All claims activities and services are performed and provided by DOXA Claims, LLC, a Florida limited liability company licensed as an insurance claims administrator in all jurisdictions in which services are provided. For more information regarding DOXA Programs, LLC, or DOXA Claims, LLC please visit our website at www.doxa.com/compliance.

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 ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

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 ARIZONA APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

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 DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

RESIDENTS OF FLORIDA RESIDENTS 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 LOUISIANA 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 MAINE 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 OR A DENIAL OF INSURANCE BENEFITS."

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 OKLAHOMA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

RESIDENTS OF PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

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 TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICTION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

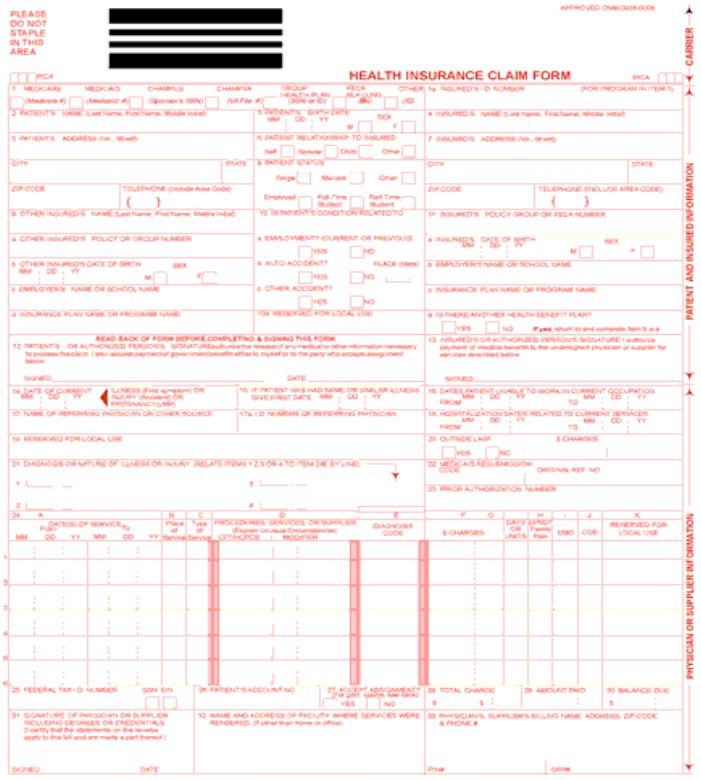
RESIDENTS OF VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

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

RESIDENTS OF WEST VIRGINIA 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."

This is a sample of an itemized bill. Balance due statements or summary of accounts are not itemized bills. Please submit itemized bills so we may promptly review claims.

SAMPLE HCFA 1500



PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

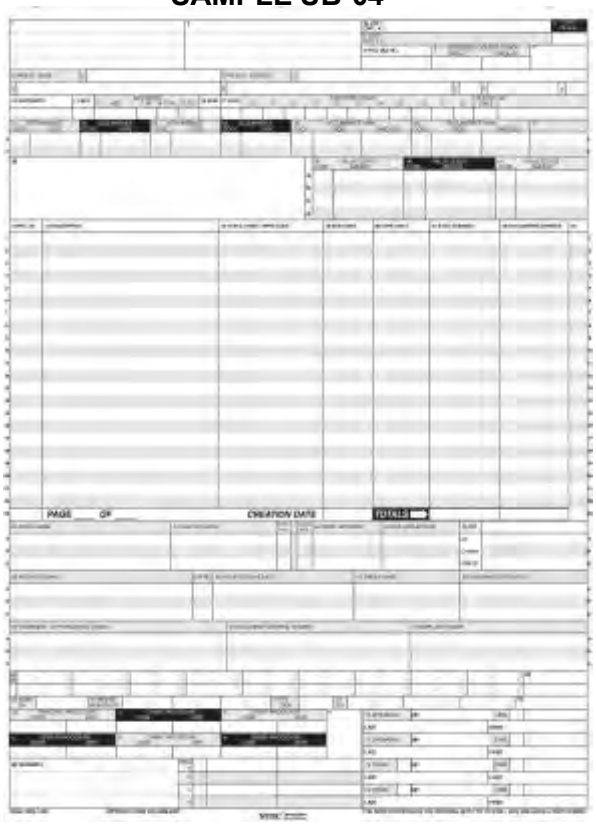
CARRIER

PATIENT AND INSURED INFORMATION

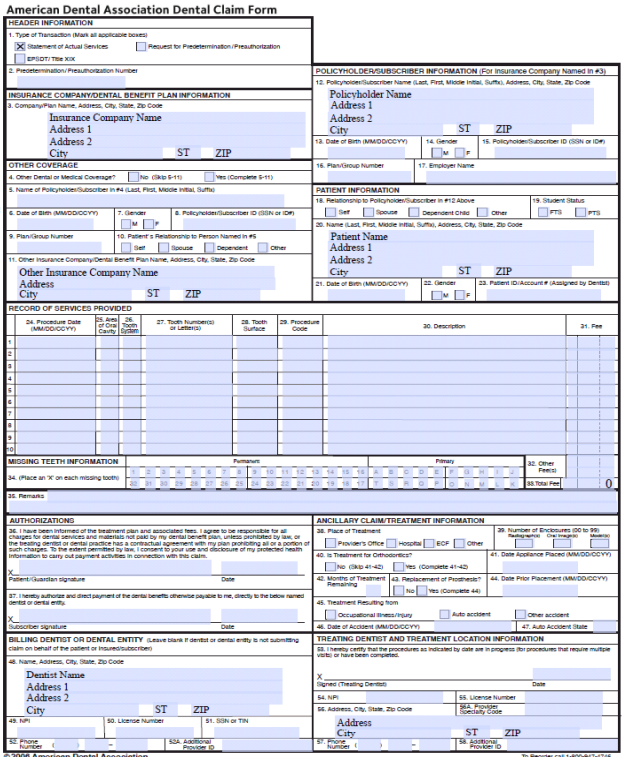
PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

SAMPLE UB-04



SAMPLE ADA DENTAL CLAIM FORM



American Dental Association Dental Claim Form

HEADER INFORMATION

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

Insurance Company Name
Address 1
Address 2
City ST ZIP

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

Policyholder Name
Address 1
Address 2
City ST ZIP

OTHER COVERAGE

PATIENT INFORMATION

Patient Name
Address 1
Address 2
City ST ZIP

Other Insurance Company Name
Address
City ST ZIP

RECORD OF SERVICES PROVIDED

MISSING TEETH INFORMATION

AUTHORIZATIONS

ANCILLARY CLAIM/TREATMENT INFORMATION

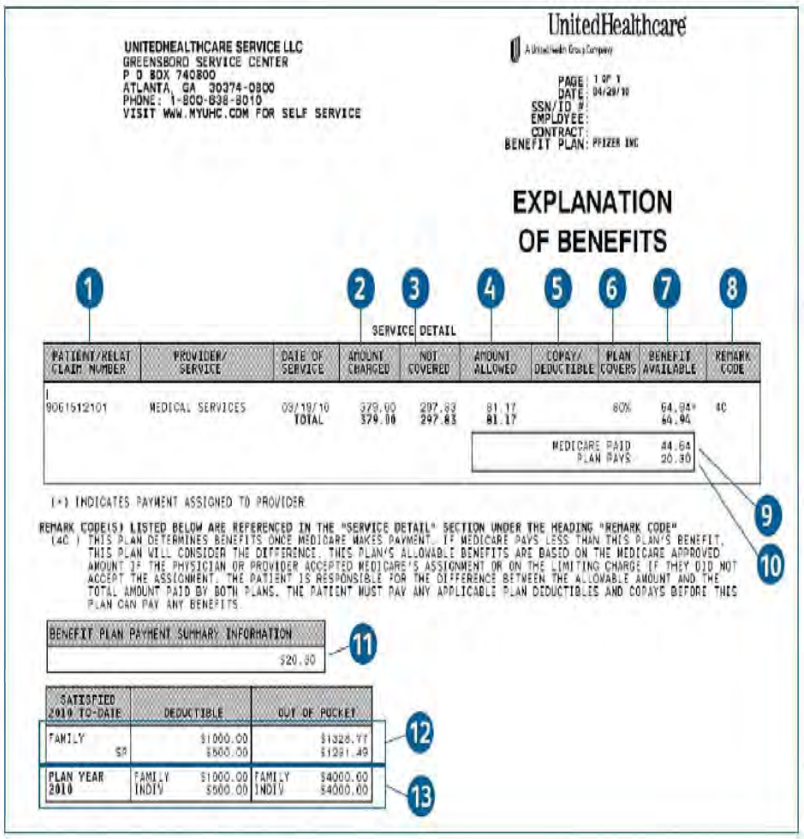
BILLING DENTIST OR DENTAL ENTITY

Dentist Name
Address 1
Address 2
City ST ZIP

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Address
City ST ZIP

SAMPLE EOB (EXPLANATION OF BENEFITS)



UnitedHealthcare
A UnitedHealth Group Company

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

PAGE: 1 OF 1
DATE: 04/20/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
90615121O1	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
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY	$1000.00	$1328.77
$?	$500.00	$1291.49
PLAN YEAR 2010	FAMILY $1000.00	FAMILY $4000.00
	INDIV $500.00	INDIV $4000.00

9
10
11
12
13