



P.O. Box 117558  
 Carrollton, Texas 75011-7558  
 Phone: (972) 512-5600 Fax: (972) 512-5818  
 Toll Free (866) 409-5734  
 Email: [K12claims@hsri.com](mailto:K12claims@hsri.com)

School District: Bridgethampton UFSD

School Name: \_\_\_\_\_

Student ID #: \_\_\_\_\_

Policy Number: WRH000015

**STUDENT CLAIM FORM**

1. Please fully complete this form
2. Attach itemized bills
3. Mail, Email or Fax to HSR

**PART I – POLICYHOLDER’S REPORT**

1. Claimant’s Name (injured/ill person)		2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Injured Person				7. Phone Number (include area code)	
8. Parent/Legal Guardian Name, Address, City, State & Zip				9. Phone Number (include area code)	
10. Date of Accident/Illness	11. Time of Accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	12. Place where Accident Occurred		13. Date of First Treatment	
Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details					
18. Which Best Describes the Activity:					
<input type="checkbox"/> Play or practice of interscholastic sports		<input type="checkbox"/> During lunch hour		<input type="checkbox"/> Athletic period	
<input type="checkbox"/> Not school related		<input type="checkbox"/> In school bus		<input type="checkbox"/> On school property during school hours	
<input type="checkbox"/> P.E. class		<input type="checkbox"/> School sponsored field trip		<input type="checkbox"/> School sponsored activity during school hours	
		<input type="checkbox"/> Traveling to/from school		<input type="checkbox"/> ROTC activity	
19. Name of Person Supervising the Activity			20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?		
Signature of Parent/Legal Guardian: X _____ Date: _____			Signature of School Official: X _____ Date: _____		

**PART II – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree?  Yes  No

If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

If applicable, claimant’s primary employer name, address, and phone number \_\_\_\_\_

If applicable, mother’s primary employer name, address, and phone number \_\_\_\_\_

If applicable, father’s primary employer name, address, and phone number \_\_\_\_\_

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**  
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian: X _____ Date: _____	Signature of Witness: X _____ Date: _____
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**PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**New York Fraud Warning Notice: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.**

## FRAUD WARNING NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of 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.

### STATE SPECIFIC PROVISIONS

<b>Alabama</b>	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
<b>Alaska</b>	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.
<b>Arizona</b>	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.
<b>Arkansas Louisiana</b>	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.
<b>California</b>	For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.
<b>Colorado</b>	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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
<b>Connecticut</b>	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
<b>Delaware Idaho</b>	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
<b>District of Columbia</b>	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.
<b>Florida</b>	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.
<b>Hawaii</b>	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
<b>Indiana</b>	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
<b>Kentucky</b>	Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
<b>Maine</b>	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 denial of insurance benefits.
<b>Maryland</b>	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>Michigan North Dakota South Dakota</b>	Any person who knowingly and with intent to defraud any insurance company or another person, files a 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 subject the person to criminal civil penalties.
<b>Minnesota</b>	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>Nevada</b>	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
<b>New Hampshire</b>	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.
<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>	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 civil fines and criminal penalties.
<b>New York</b>	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 material fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
<b>Ohio</b>	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.
<b>Oklahoma</b>	WARNING: 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.
<b>Oregon</b>	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 thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
<b>Pennsylvania</b>	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.
<b>Rhode Island West Virginia</b>	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.
<b>Tennessee Virginia Washington</b>	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.
<b>Texas</b>	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.
<b>Utah</b>	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

Listed below are important instructions and comments about filing a claim.

#### **YOUR CLAIM FORM**

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.  
**Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to **HSR** for you.

#### **YOUR BILLS**

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to **HSR** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on your bill, we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim and will be denied for an itemized bill.

#### **EXCESS INSURANCE**

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. **HSR** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

***Health Special Risk, Inc.***  
**P.O. Box 117558**  
**Carrollton, TX 75011-7558**

# Student Accident Claims

The following will assist parents/guardians with submitting a Student Accident claim. The claim should be submitted within 90 days of the date of the accident, even if all the needed documentation is not yet available. If the claim form is not submitted within 90 days of the date of the accident, the claim could be denied for late filing. To expedite claim processing, it is important that all required information is provided – see details below. Student Accident Insurance is a secondary insurance plan which is available to you when your child is injured in a school supervised and sponsored activity. This is intended to be **Excess** coverage, secondary to a student's normal health insurance. All medical expenses for accidental injuries should be submitted to your health plan first. If you do not have health insurance, the Student Accident plan will provide benefits for covered accidents according to the policy's schedule of covered expenses. Please include the school name and student accident policy number on any documentation submitted for the claim.

1. Claim Form – This form can be obtained from the school. The school can print out the form for the parents/guardians. The school can also email the form to the parent/guardian, as most of the information can be typed into the Claim form, which is a fillable PDF.
  - a. STUDENT INFORMATION (Parts 1-9) – All information related to the student must be included. Social Security Number optional. Cell phone number should be for the parent/guardian that can be easily contacted if there are any questions.
  - b. ACCIDENT INFORMATION (Parts 10-20) – All information related to the accident including activity, date of accident, body part injured, where the accident occurred and details of the accident.
  - c. AUTHORIZATION – This section must be signed by the parent/guardian and a school official such as a coach, athletic trainer or nurse. The school official might want to sign off after including the information about the accident and then give to the parent/guardian to submit to HSR.
  - d. INSURANCE INFORMATION - Parent/guardian needs to complete this section including their primary health insurance information with policy and ID number. If the parents/guardians do not have medical/dental insurance, this must be noted on the form. To avoid delays in claim processing, insurance section of the claim form must be completed in full.

2. Itemized Bills (include school name and policy number) – This can be obtained from the treating physician’s or dentist’s office. It will include the name and address of the provider of service, date of service, type of service and the related charges. Even though account statements or “balance due” statements are helpful, they do not contain all the information needed to process the charges. To avoid delays in claim processing, an Itemized Bill should be provided.
3. Explanation of Benefits (EOB) (include school name and policy number) - If the student has health insurance, all medical bills must first be submitted to their primary health insurance carrier. A copy of the “Explanation of Benefits” form provided by the primary carrier, must be submitted with the claim. If the student does not have primary medical insurance, the need for an “Explanation of Benefits” will not be applicable to the claim, and only the Claim Form, along with the Itemized Bills, should be submitted.
4. Once all information is completed on the Claim form, and all the necessary documents have been gathered, the claim can be submitted via mail, email or fax to the third-party administrator, Health Special Risk, Inc., by the parents/guardians.

**Mail**

Health Special Risk, Inc.  
Claims Department  
P.O. Box 117558  
Carrollton, TX 75011-7558

**Email** - [K12claims@hsri.com](mailto:K12claims@hsri.com)

Include school name, policy number and student name in the Subject.

**Fax** - (972)- 512-5818

Include school name, policy number and student name on the cover page of the Fax.

5. Claims Status - To find out the status of a claim, parents/guardians can contact HSR, Inc. as follows:

**Phone:**           **(866) 409-5734**

The parent/guardian can also visit HSR’s website and complete a form electronically. A member of HSR’s team will then be in touch with the parent/guardian.

The link to the form is:

<https://www.hsri.com/forms/claim%20forms-approved/K12%20Claim%20Form.pdf>