VAcorp

Best Practices:
Student Accident Claims Reporting

Presented by
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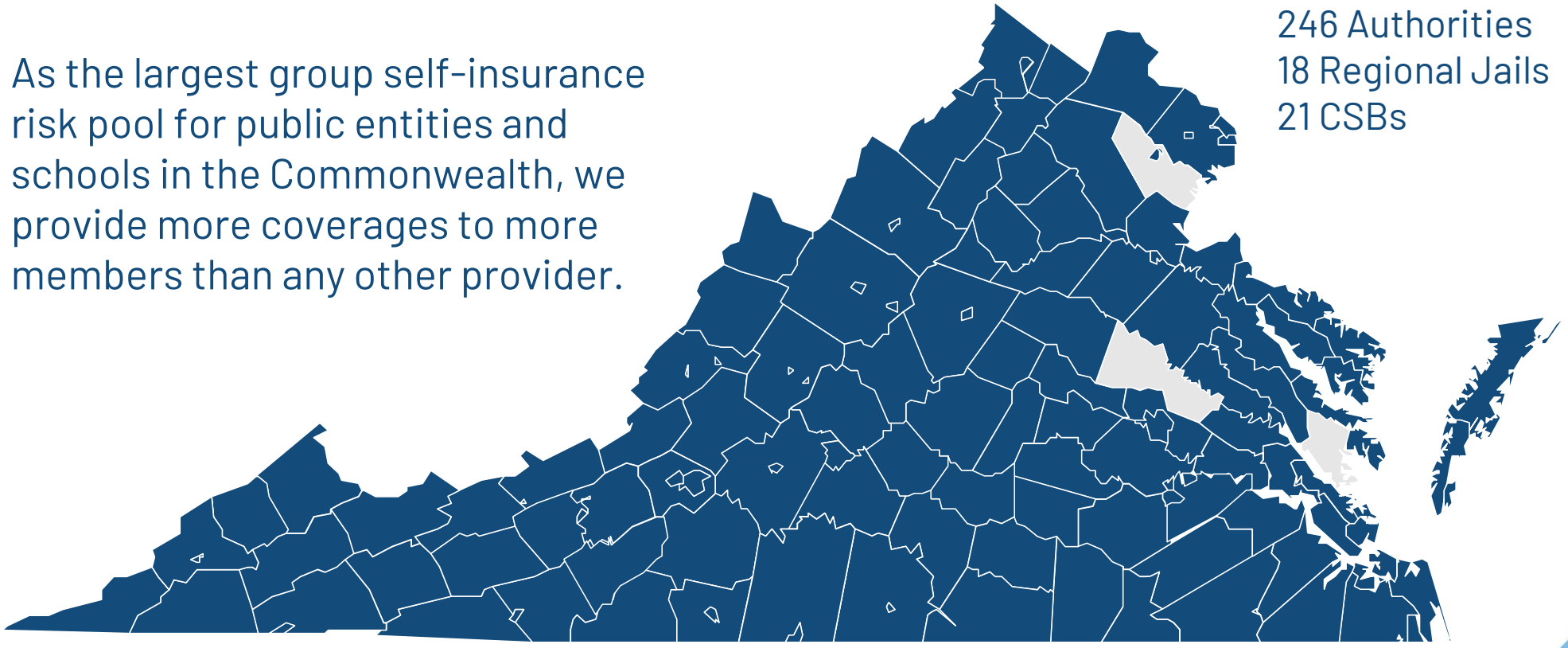
We know the unique risks you face.
We know how to respond.

Our strength is in our numbers.
Our stability is in our members.

As the largest group self-insurance risk pool for public entities and schools in the Commonwealth, we provide more coverages to more members than any other provider.

527 Members
88 Counties
126 School Divisions
28 Municipalities
246 Authorities
18 Regional Jails
21 CSBs



VAcorp

We've got you covered.

Today's Agenda

- Compare student accident and GL medical payments coverage
- Review claims reporting process
- Review the importance of timely reporting
- Review where to send follow-up information
- Review Catastrophic Student Accident Coverage Program
- Respond to your questions

Student Accident vs. Medical Payments

- Medical payments under GL
- Students are “excluded”
  - only covered if purchased to add back coverage

Student Accident Claims Overview

- Claim Forms
- Secondary to any other insurance
- Claims handled by experienced professionals
- Claim form must be received within 90 days
  - signed by parent or guardian

Student Accident Claim Process

Action Items when Student is Injured at School*

- Complete internal incident report
- Complete school section of claim form
- Provide claim form to parent for signature
- Forward signed form within 90 days to VAcorp using online claim reporting tool
  - Contact your Central Office or Member Services for login
- VAcorp will contact parent for information, bills

*School-sponsored event/activity; athletics may be added

Claim Form Part 1: Incident Information

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division:

_____

School Name:

_____

School Address:

_____

Student's Name:

_____

☐ Male ☐ Female Date of Injury: _____ Date of Birth: _____

Grade Level: _____

Body Part: _____ Diagnosis: _____

Description of Accident (Include an additional page if needed):

_____

_____

_____

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? ☐ Yes ☐ No

Under whose supervision? _____ Phone #: _____

Website Assigned Claim Number: _____

Signature of Preparer: _____ Title: _____

Printed Name: _____ Date: _____ Phone #: _____

Claim Form Part 2: Parent Information

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION) *If additional room is needed, please feel free to use another piece of paper*

Student Information:

Student Address: _____ Student SSN: _____-_____-_____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer:

_____

Employer's Address:

_____

Mother's Name: _____ Phone #: _____

Mother's Employer:

_____

Employer's Address:

Please list **ALL** insurance policies: ☐ Medicare/Medicaid ☐ Check if No Insurance

Name of Insurer:

_____

Address: _____ Policy #:

_____

Phone #: _____ ☐ Group ☐ Individual HICN (if Medicare):

_____

Name of Policyholder: _____

Initial Treating Physician:

Physician/ Facility Name:

_____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Claim Form Page 2: Instructions

CLAIM INSTRUCTIONS: In case of accident, notify the school immediately.

Student Accident coverage is only available to cover students for accidental injury occurring while Contract is in force.

1. Complete this claim form, sign, and return it to the school division within 90 days from the date of injury. This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed. **If the claim form is submitted to VACORP after 90 days of the date of injury, the claim will not be considered for payment.**
2. All expenses must be incurred and reported to VACORP within a year of the date of accident. Any expenses incurred and/or reported to VACORP more than 365 days after the accident will not be considered for payment.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanation of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will ***not*** be accepted.
4. When you receive an EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the parent/guardian, who must pay the medical provider(s).
6. VACORP will not issue payment on any claim until a Social Security Number and Date of Birth of the claimant is provided per MMSEA guidelines. In Lieu of a SSN, a Medicare Health Insurance Claim Number (HICN) may be submitted.
7. All claims are subject to the terms, conditions and exclusions found in the coverage document. The coverage contract supersedes any contradictory statements contained herein.

Benefits are provided on a ***SECONDARY*** excess basis for covered expenses. Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including, Medicaid, Medicare, FAMIS, and private health insurance. You must follow any requirements for obtaining health care benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the Contract provisions.

Claim Form Page 2: Authorization

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize all medical service sources and health care providers to disclose a complete copy of my health records, including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse to Virginia Association of Counties Group Self-Insurance Risk Pool, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as VACORP).

I authorize the use of the above information for VACORP to investigate, process and determine the amount payable, if any, for all claims made under any VACORP property and casualty contract that applies to the accident or occurrence on _____. I understand as part of the claim handling process, VACORP may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professional for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that VACORP has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s). This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

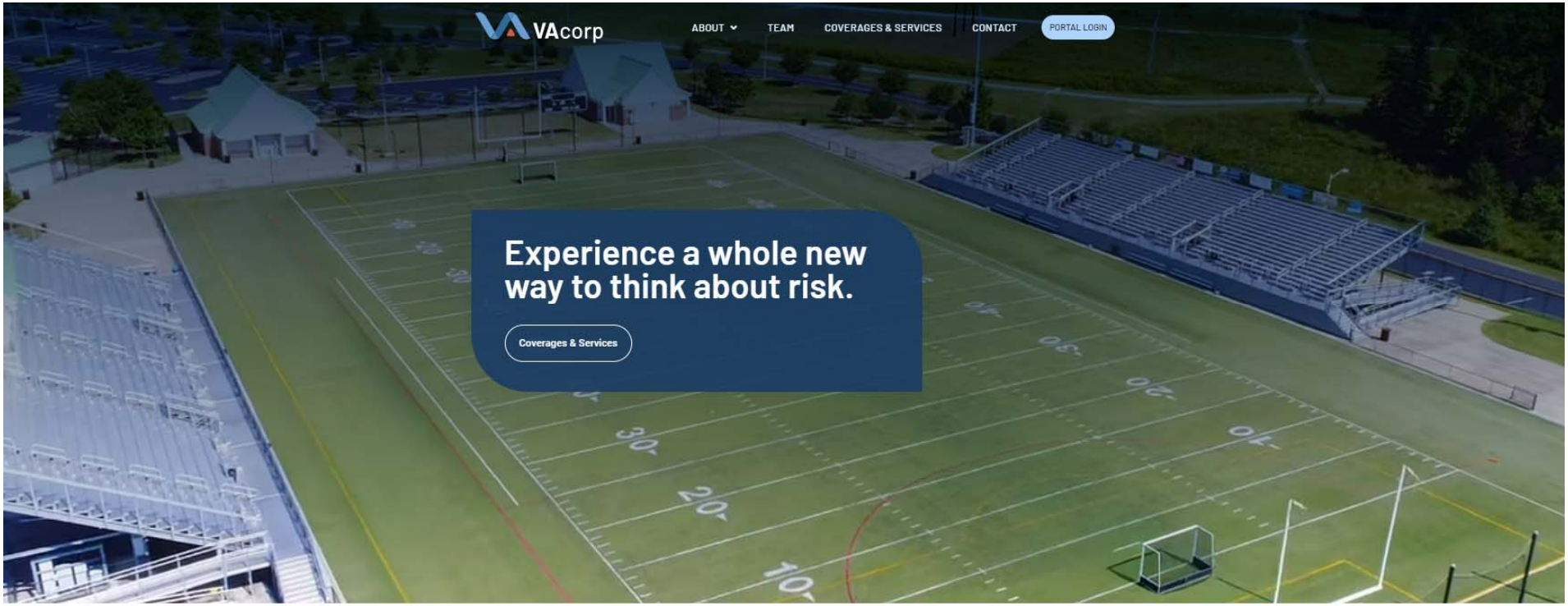
I have read the authorization and signed this document. I verify that the statement in Part 2 about other insurance is accurate and complete. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract. 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.

Any payment will be made directly to the parent/guardian, who must pay the medical provider(s).

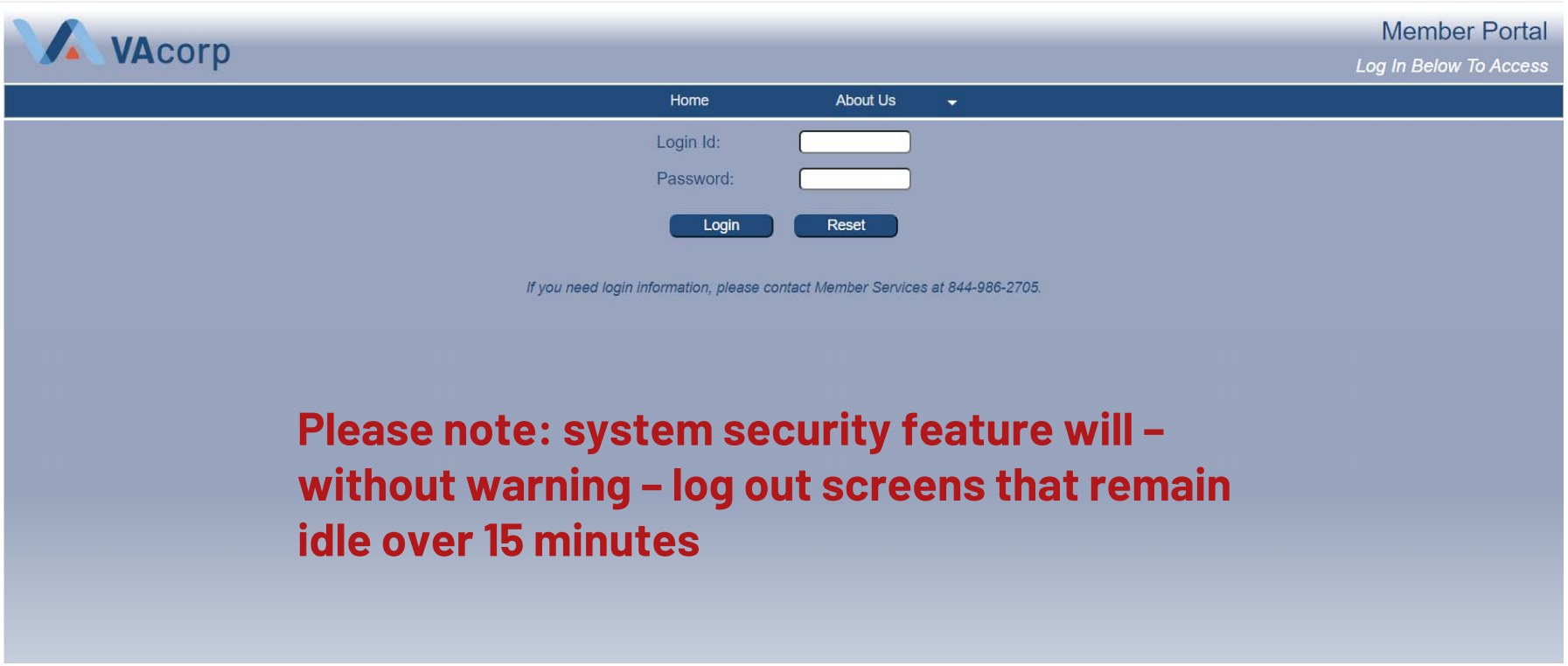
Parent or Authorized Representative's Signature: _____ Date: _____If Authorized Representative, Relationship to Student or Legal Designation: _____

Reporting Claims Online

Go to www.VAcorp.org and login to the Member Portal

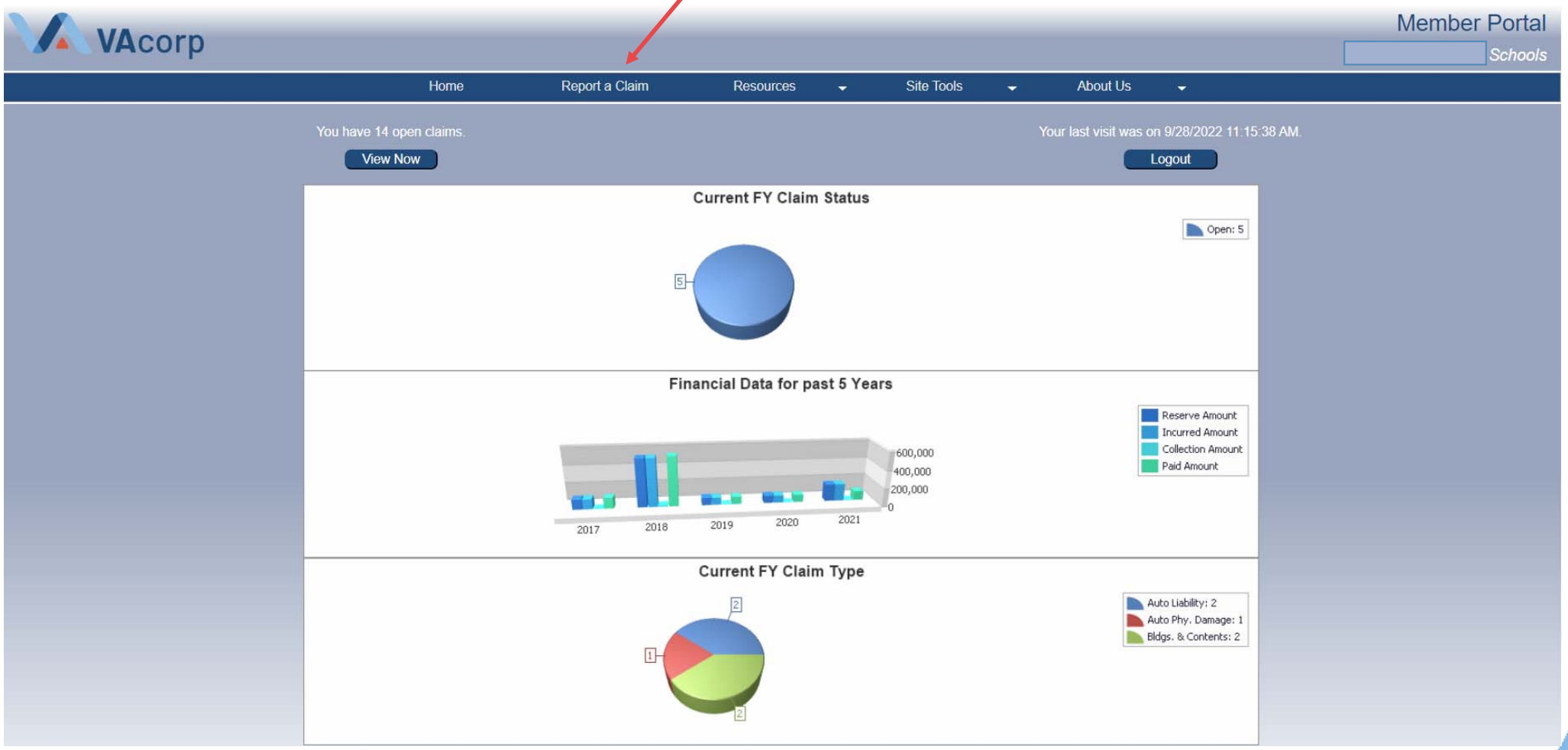


Reporting Claims Online



Please note: system security feature will – without warning – log out screens that remain idle over 15 minutes

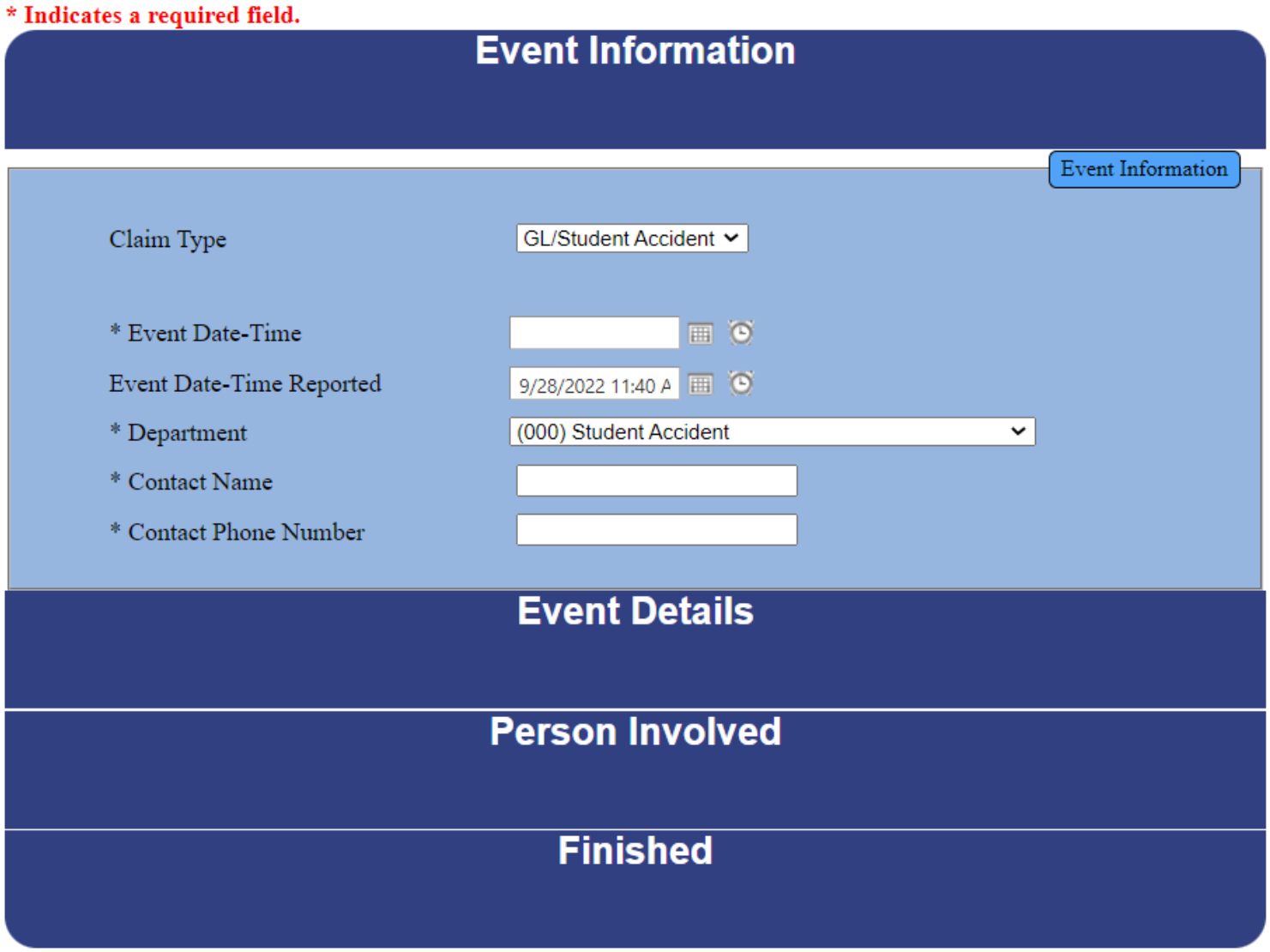
Reporting Claims Online



Reporting Claims Online

- Login to www.VAcorp.org; select “Report a Claim”, which opens a new window and presents four boxes labeled as follows:
  - Event Information
  - Event Details
  - Person Involved
  - Finished
- Complete as much information as available
- Fields marked with an asterisk (*) must be completed before submitting

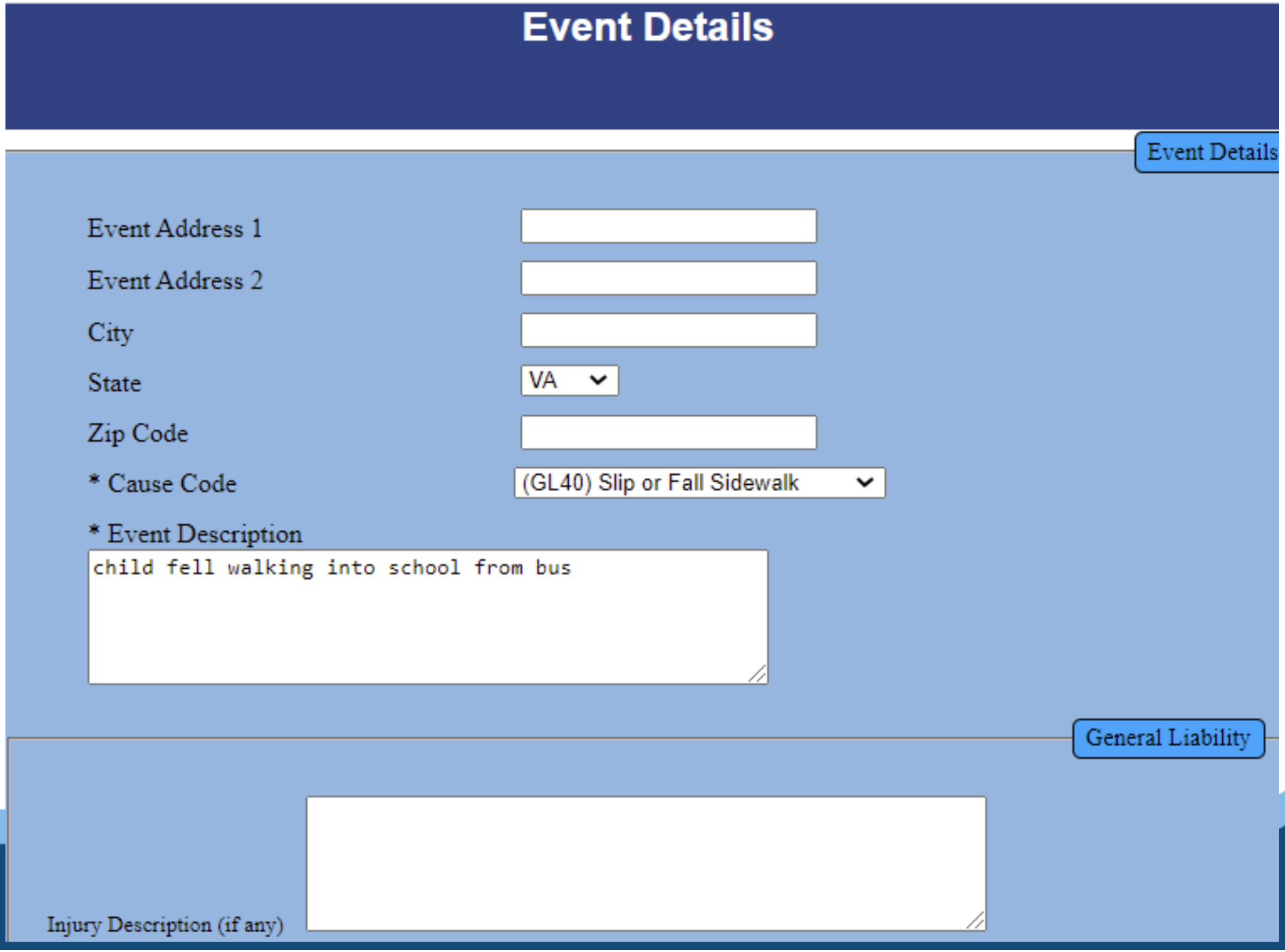
Claim Date Entry Box 1: Event Info



Claim Data Entry Box 1: Event Info

- Claim Type: Default is GL/Student Accident
- Event Date/Time: click on calendar/clock
- Department: Student Accident
- Enter Contact Name and Phone Number for employee that can best answer questions about the claim

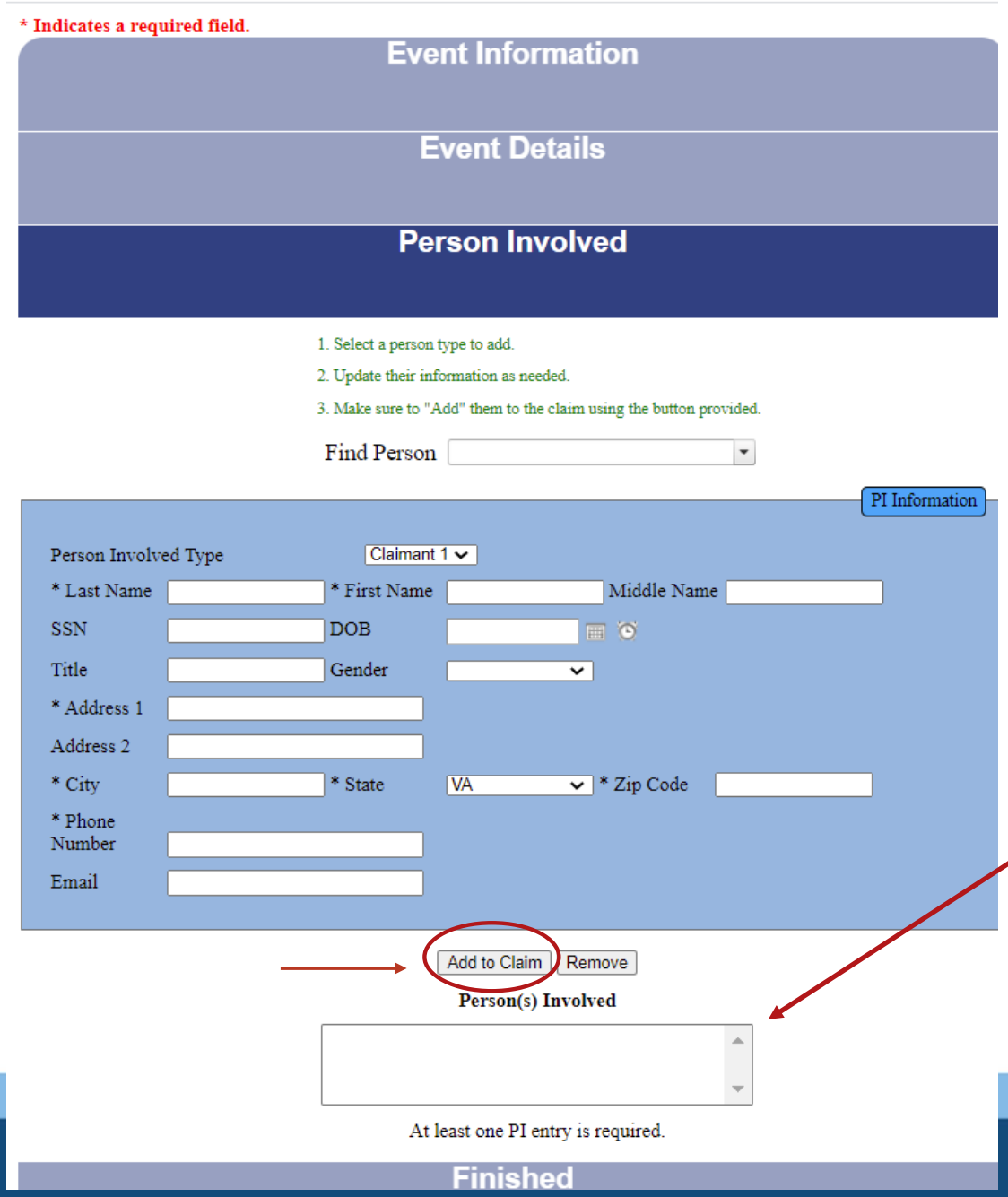
Claim Date Entry Box 2: Event Details



Claim Data Entry Box 2: Event Details

- Fields with * must be completed
- Provide as much information as available
- Cause Code: select best match
- Event Description:
  - enter brief description or indicate “see attached claim form”

Claim Date Entry Box 3: Persons Involved

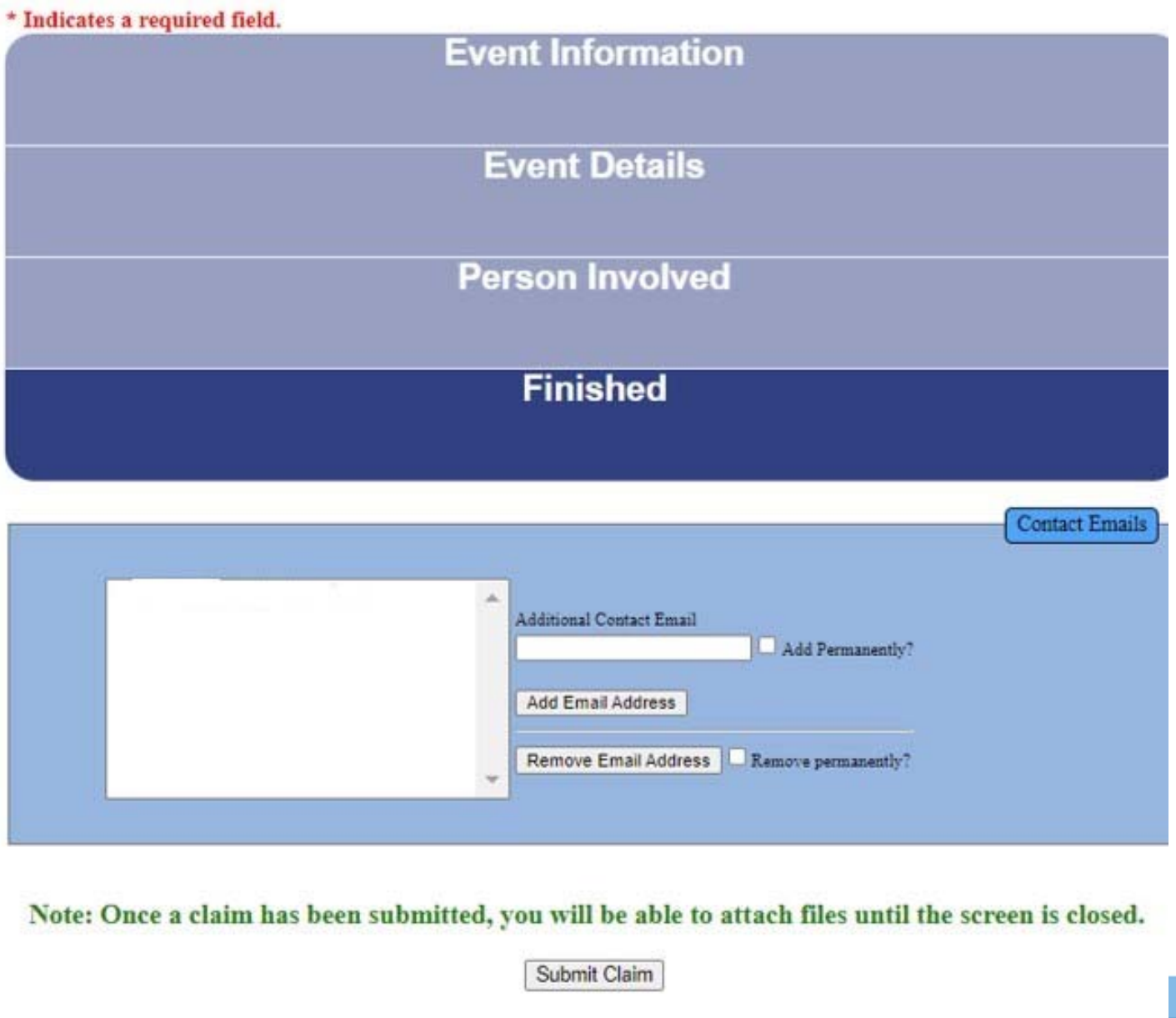


When entering information about the student, please click "Add to Claim" so their name appears in the "Person Involved" box

Claim Data Entry Box 3: Persons Involved

- Enter Student Information - REQUIRED
  - First and Last Name
  - Address
  - Phone Number
- Must click “Add to Claim” for info to be saved
- Other info will be on claim form submitted

Claim Date Entry Box 4: Finished



Claim Data Entry Box 4: Finished

- Enter email address for person(s) to receive claim confirmation email from VAcorp
- Click Submit Claim, reveals **unique claim number**

NOW attach/upload completed claim form:

- Select Upload Attachment
  - Locate claim form / other documents saved to your device
  - You may send multiple docs, until tab closed
- After closing web claim window, send docs via email
  - Mark doc with unique claim number
  - Email to tech1@riskprograms.com

Claims Handling

- Signed claim form must be received within 90 days
- After form received, VAcorp works with parent/guardian
- Amount paid based on schedule of benefits
  - selected by the school division
- Payment is secondary to any other insurance

Federal Requirements

- Medicare, Medicaid and SCHIP Extension Act (MMSEA) requires VAcorp to provide specific information to Medicare
- Required Info:
  - Full Name
  - Date of Birth
  - Gender
  - SSN or health insurance claim number (HICN)
- Information must be received before payments are made

Student Accident Claims Recap

- VAcorp is secondary to any other insurance
- Claims handled by knowledgeable professionals
- Follow-up info sent to tech1@riskprograms.com
  - additional documents, medical bills, EOBs
  - write school division name and claim number on all correspondence
- Required info must be received before payment made

Schedule of Benefits

Benefit	Standard Plan	Economy Plan	Deluxe Plan
Medical Expense Limit	$5,000	$10,000	$25,000
Inpatient Room and Board – Usual and Customary – Semiprivate Room	$300 First Day $150 Each Additional Day	$500 First Day $300 Each Additional Day	$1,000 First Day $700 Each Additional Day
Day Surgery	Up to $500	Up to $1,000	Up to $1,500
Outpatient Physician Visit Expense	$20	$30	$50
Outpatient Physiotherapy Expense	$20/Day Up to $100	$30/Day Up to $250	$50/Day Up to $500
Outpatient Emergency Room Expense	Up to $250	Up to $500	Up to $750
Outpatient X-Ray Expense	Up to $100	Up to $250	Up to $500
Laboratory	U&C	U&C	U&C
Prescriptions	U&C	U&C	U&C
Outpatient Durable Medical Equipment and Supplies Expense	Up to $100	Up to $200	Up to $300
Surgeon Expense	U&C Up to $1,000	U&C Up to $2,000	U&C Up to $3,000
Assistant Surgeon	30% of Amount Paid for Surgeon	30% of Amount Paid for Surgeon	30% of Amount Paid for Surgeon
Anesthetist or Anesthesiologist Expense	30% of Amount Paid for Surgeon	30% of Amount Paid for Surgeon	30% of Amount Paid for Surgeon
Ambulance Expense	Up to $100	Up to $250	Up to $500
Air Ambulance	Up to $5,000	Up to $5,000	Up to $5,000
Consultant	Up to $100	Up to $250	Up to $500
Outpatient Dental Accident Expense	$150/Tooth $600 Max	$250/Tooth	$600/Tooth
Licensed Nurse Expense	$70/Day	U&C	U&C
Heat Exhaustion and Sunstroke	$100	$500	$1,000

Student Accident Coverage

- Standard, Economy, and Deluxe
- Catastrophic Student Accident
- VHSL Catastrophic Student Accident
- Coverage gaps
- Timely Reporting
- Secondary Coverage definition
- Pitfalls to avoid

Catastrophic Student Accident Program

- Fills coverage gaps of VHSL Cat Program
  - –Out of Season Sports Practices and Scrimmages
  - –Middle School Sports
  - –Catastrophic Injuries
- Coverage is secondary to other insurance
- Limits available up to $3,000,000
  - $25,000 deductible
- Report claims as soon as injury is known

Catastrophic Claim Form

Please select one of the following: ☐ Fatality ☐ Catastrophic Injury

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division:

_____

School Name:

_____

School Address:

_____

Student's Name:

_____

☐ Male ☐ Female Date of Injury/Fatality _____ Date of Birth: _____

Grade Level: _____

Body Part: _____ Diagnosis: _____

Description of Accident (Include an additional page if needed):

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? ☐ Yes ☐ No

Under whose supervision? _____ Phone #: _____

Website Assigned Claim Number: _____

Signature of Preparer: _____ Title: _____

Printed Name: _____ Date: _____ Phone #: _____

Catastrophic Claim Form – Part 2

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION) *If additional room is needed, please feel free to use another piece of paper*

Student Information:

Student Address: _____ Student SSN: _____-_____-_____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer: _____

Employer's Address: _____

Mother's Name: _____ Phone #: _____

Mother's Employer: _____

Employer's Address: _____

Please list **ALL** insurance policies: ☐ Medicare/Medicaid ☐ Check if No Insurance

Name of Insurer (1): _____

Address: _____

Policy #: _____ HICN (if Medicare): _____

Phone #: _____ ☐ Group ☐ Individual Name of Policy Holder: _____

Name of Insurer (2): _____

Address: _____

Policy #: _____ HICN (if Medicare): _____

Phone #: _____ ☐ Group ☐ Individual Name of Policy Holder:

_____

Catastrophic Claim Form – Treatment Info

Treatment Information; Name and addresses of doctors attending the student following the accident:

Physician/ Facility Name (1): _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Physician/ Facility Name (2): _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Physician/ Facility Name (3): _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Was this accident reported to the police department? ☐ Yes ☐ No

If yes, indicate the name of the police department:

If fatality, was an autopsy conducted? ☐ Yes ☐ No If so, who conducted the autopsy (Name and address)

Did the deceased have any chronic disease, physical defects or deformities? ☐ Yes ☐ No If yes, please describe:

Catastrophic Claim – Instructions & Release

Instructions:

In case of an accident, notify the school immediately.

Student Accident coverage is only available to cover students for accidental injury occurring while Contract is in force.

1. Complete this claim form, sign, and return it to the school division within 365 days from the date of injury. This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed. **If the claim form is submitted to VACORP after 365 days of the date of injury, the claim will not be considered for payment.**
2. Treatment must begin within 180 days to be considered; expenses must be incurred within 5 years of the date of accident. **Any expenses incurred more than 5 years after the accident will not be considered for payment.**
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will ***not*** be accepted.
4. When you receive an EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.
6. If the incident resulted in a fatality, please attach a copy of the death certificate to this form. Only a copy of the death certificate is required, not a certified certificate.
7. VACORP will not issue payment on any claim until a Social Security Number and Date of Birth of the claimant is provided per MMSEA guidelines. In lieu of a SSN, a Medicare Health Insurance Claim Number (HICN) may be submitted.
8. All claims are subject to the terms, conditions and exclusions found in the coverage document. The coverage contract supersedes any contradictory statements contained herein.

Review Student Accident Claims & CAT Program

- Coverage is secondary to other insurance
- Submit signed claim form within 90 days of injury
  - Use online claim reporting tool
  - Contact your Central Office or Member Services for login
  - Scan/save completed claim form/other documents prior to login
- Claim inquiries call customer services line 888-822-6772
- Coverage available for Catastrophic injuries and death
  - Out of Season sports practices and scrimmages
  - Middle School sports
  - Tragic accidents, such as lab explosions
  - $25,000 deductible

Questions

For additional information, contact:

Lee Brannon, LBrannon@riskprograms.com
Michael Thornton, Mthornton@riskprograms.com

VAcorp is proud to be your one-stop provider of coverage and risk management services.

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Thank You!